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**RESEARCH FACILITIES, MENTAL HEALTH STAFFING,
CONTINUATION OF HEALTH PROGRAMS, AND
GROUP PRACTICE**

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**HEARINGS
BEFORE THE
COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES
EIGHTY-NINTH CONGRESS**

FIRST SESSION

ON

H.R. 2984

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT PROVISIONS FOR CONSTRUCTION OF HEALTH RESEARCH FACILITIES BY EXTENDING THE EXPIRATION DATE THEREOF AND PROVIDING INCREASED SUPPORT FOR THE PROGRAM, TO AUTHORIZE ADDITIONAL ASSISTANT SECRETARIES IN THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, AND FOR OTHER PURPOSES

H.R. 2985

A BILL TO AUTHORIZE ASSISTANCE IN MEETING THE INITIAL COST OF PROFESSIONAL AND TECHNICAL PERSONNEL FOR COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

H.R. 2986

A BILL TO EXTEND AND OTHERWISE AMEND CERTAIN EXPIRING PROVISIONS OF THE PUBLIC HEALTH SERVICE ACT RELATING TO COMMUNITY HEALTH SERVICES, AND FOR OTHER PURPOSES

H.R. 2987

A BILL TO AUTHORIZE MORTGAGE INSURANCE AND LOANS TO HELP FINANCE THE COST OF CONSTRUCTING AND EQUIPPING FACILITIES FOR THE GROUP PRACTICE OF MEDICINE OR DENTISTRY

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RESEARCH FACILITIES, MENTAL HEALTH STAFFING, CONTINUATION OF HEALTH PROGRAMS, AND GROUP PRACTICE

TUESDAY, MARCH 2, 1965

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met at 10 a.m., pursuant to call, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will come to order.

Today the committee is assembled for hearings on four bills which I introduced at the request of the Department of Health, Education, and Welfare, to carry out a part of the President's health message recently sent to the Congress.

The first of these bills is H.R. 2984, which amends the Public Health Service Act to extend the current program of grants for construction of health research facilities, a well-known program which has contributed so much to our health program throughout the country. It would also add a new program of grants for construction of specialized regional or national research facilities.

This program was proposed by Senator Hill several years ago. The bill also has another fairly noncontroversial problem in it, and that is the addition of three Assistant Secretaries of Health, Education, and Welfare.

Let me say my comment might have been considered to be facetious, but I do think in all sincerity, we should provide this rank for these people who are assuming responsibilities in such a vast organization as HEW, and who are now carrying out the duties and responsibilities of those positions. There will be very little money involved insofar as salaries or wages are concerned. This Department is such an important one to our Nation, and particularly to our people they serve, that in my judgment the time has come to give status to those who are carrying out such a great responsibility.

The second bill, H.R. 2985, would amend the Mental Retardation Facilities and Community Mental Health Centers Construction Act to authorize grants for the initial costs of staffing the community mental health centers.

This is a question that the committee considered during the last Congress. Everyone knows, of course, what the result was. It is obvious from the experience that we have had in trying to get this program off center that some assistance in this field seems to be imperative. The grants would be for a period of 4 years and 3 months for each center, and would be made on a declining basis, with 75 percent Federal matching funds for the first 15 months; 60 percent for the next

year; 45 percent the following year, and, finally, 30 percent, with no grants being made thereafter.

This proposal was contained in the legislation which became Public Law 88-164. We have now had over 16 months of experience in the operation of the act and are in a better position to determine not only the merits, but the justification for the staffing proposal.

Then we have H.R. 2986, introduced at the same time, providing for an extension of four expiring programs under the Public Health Service Act. It will provide a 5-year extension of the current mass vaccination program and expands the coverage of this program to include measles and other diseases presenting a major public health problem.

It would extend for 5 years the program under which health services are provided to domestic migratory agricultural workers, a well-known program, too.

The other bill, H.R. 2987, would amend the Public Health Service Act to authorize a program of mortgage insurance and loans to help finance the costs of constructing and equipping facilities for the group practice of medicine or dentistry.

We expect to develop the issues contained in these bills fully and completely during the course of the hearings this week. At this point copies of the bills will be inserted into the record and the reports that have been received.

(The bills and reports follow:)

[H.R. 2984, 89th Cong., 1st Sess.]

A BILL To amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Research Facilities Amendments of 1965".

HEALTH RESEARCH FACILITIES CONSTRUCTION GRANTS

SEC. 2. (a) Section 704 of the Public Health Service Act (hereinafter referred to as the "Act") is amended by inserting after "\$50,000,000," the following: and for the fiscal year ending June 30, 1967, and the four succeeding fiscal years, an aggregate of not to exceed \$400,000,000," and by inserting "(other than facilities constructed under section 712)" after "facilities".

(b) Subsection (a) of section 705 of the Act is amended by striking out "June 30, 1965" and inserting in lieu thereof "June 30, 1970".

(c) Part A of title VII of the Act is amended by inserting after section 711 the following new section:

"CONSTRUCTION AND OPERATION OF SPECIALIZED REGIONAL OR NATIONAL FACILITIES

"SEC. 712. (a) When the Surgeon General finds, in accordance with regulations, that the purposes of this part can best be achieved through the construction of research, or research and related purposes, facilities of particular value or significance for the Nation or a region thereof, and that because of the cost of such facilities or their use as a national or regional resource for research or related purposes a grant pursuant to the preceding provisions of this part does not provide an effective or appropriate means of financing the construction of such facilities, he may construct or make arrangements for constructing, through contracts for paying (including advance or installment payments) part of all of the cost of construction or otherwise, facilities for the conduct of research, or for research and related purposes, in the sciences related to health. The Surgeon General may, where he deems such action appropriate, make arrangements, by contract or otherwise, for the operation of such facilities (for the conduct of such research, or research and related purposes) or may make contributions toward the cost of

such operation of facilities of this nature whether or not constructed pursuant to, or with aid provided under, this section. Title to any facility constructed under this section may be transferred by the Surgeon General on behalf of the United States to any public or nonprofit private institution competent to engage in the type of research, or research and related purposes, for which the facility was constructed. Such transfer shall be made subject to the condition that the facility will be operated for the research, or research and related purposes, for which it was constructed and to such other conditions as the Surgeon General deems necessary to carry out the objectives of this part and to protect the interests of the United States. Any laborer or mechanic employed by any contractor or subcontractor in the performance of work on the construction of any facility constructed under this section shall be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5). The Secretary of Labor shall have, with respect to labor standards specified in the preceding sentence, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 64 Stat. 1267), and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

“(b) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1966, and the five succeeding fiscal years such sums as may be necessary for carrying out this section; and any sums appropriated for construction pursuant to this section shall remain available until expended.”

(d) So much of section 707 of the Act as precedes clause (a) is amended by striking out “funds have been paid” and inserting in lieu thereof “a grant has been made”.

CONTRACTS FOR RESEARCH

SEC. 3. Section 301 of the Act is amended by striking out “and” at the end of subsection (g), by redesignating subsection (h) as subsection (i), and by inserting immediately before such subsection the following new subsection:

“(h) Enter into contracts for research in accordance with and subject to the provisions of law applicable to contracts entered into by the military departments under title 10, United States Code, sections 2353 and 2354, except that determination, approval, and certification required thereby shall be by the Secretary of Health, Education, and Welfare; and”.

ADDITIONAL ASSISTANT SECRETARIES OF HEALTH, EDUCATION, AND WELFARE

SEC. 4. (a) There shall be in the Department of Health, Education, and Welfare, in addition to the Assistant Secretaries now provided for by law, three additional Assistant Secretaries of Health, Education, and Welfare, who shall be appointed by the President, by and with the advice and consent of the Senate. The provisions of section 2 of the Reorganization Plan Numbered 1 of 1953 (67 Stat. 631) shall be applicable to such additional Assistant Secretaries to the same extent as they are applicable to the Assistant Secretaries authorized by that section.

(b) The office of Special Assistant to the Secretary (Health and Medical Affairs), created by section 3 of the Reorganization Plan Numbered 1 of 1953 (67 Stat. 631), is hereby abolished.

(c) Paragraph (17) of section 303(d) of the Federal Executive Salary Act of 1964 (78 Stat. 418) is amended by striking out “(2)” before the period at the end thereof and inserting in lieu thereof “(5)”; and paragraph (95) of section 303(e) of such Act is repealed.

(d) The President may authorize the person who immediately prior to the date of enactment of this Act occupies the office of Special Assistant to the Secretary (Health and Medical Affairs) to act as one of the additional Assistant Secretaries authorized by the first section of this Act, until that office is filled by appointment in the manner provided by such section. While so acting, such person shall receive compensation at the rate now or hereafter provided by law for Assistant Secretaries of executive departments.

[H.R. 2985, 89th Cong. 1st Sess.]

A BILL To authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers

Be it enacted by the Senate and House of Representatives of the United States of American in Congress assembled, That this Act may be cited as the “Community Mental Health Centers Act Amendments of 1965”.

TECHNICAL AMENDMENTS

SEC. 2. (a)(1) The Mental Retardation Facilities and Community Mental Health Centers Construction Act is amended by changing the heading of title II thereof to read "TITLE I—COMMUNITY MENTAL HEALTH CENTERS", by inserting immediately below such heading the subheading "PART A—GRANTS FOR CONSTRUCTION OF CENTERS", and by changing the words "this title" wherever they appear in such title to read "this part"; and (2) all references to such title II in titles I and IV of such Act and elsewhere are changed to read "part A of title I".

(b) Such title I is further amended by adding at the end thereof the following:

"PART B—GRANTS FOR INITIAL COST OF PROFESSIONAL AND TECHNICAL PERSONNEL OF CENTERS

"AUTHORIZATION, DURATION, AND AMOUNT OF GRANTS

"SEC. 220. (a) For the purpose of assisting in the establishment and initial operation of community mental health centers providing all or part of a comprehensive community mental health program, the Secretary may, in accordance with the provisions of this part, make grants to meet, for the temporary periods specified in this section, a portion of the costs (determined pursuant to regulations under section 223) of compensation of professional and technical personnel for the initial operation of new community mental health centers or of new services in community mental health centers.

"(b) Grants for such costs for any center under this part may be made only for the period beginning with the first month for which such a grant is made and ending with the close of four years and three months after such first month; and such grants with respect to any center may not exceed 75 per centum of such costs for the period ending with the close of the fifteenth month following such first month, 60 per centum of such costs for the first year thereafter, 45 per centum of such costs for the second year thereafter, and 30 per centum of such costs for the third year thereafter.

"APPLICATIONS AND CONDITIONS FOR APPROVAL

"SEC. 221. (a) Grants under this part with respect to any community mental health center may be made only upon application, and only if—

"(1) the applicant is a public or nonprofit private agency or organization which owns or operates the center;

"(2) the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is situated, at least those essential elements of comprehensive mental health services which are prescribed by the Secretary;

"(3) a grant was made under part A of this title to assist in financing the construction of the center or the type of service to be provided as part of such program by such center with the aid of a grant under this part was not previously being provided.

"(b) No grant may be made under this part after June 30, 1970, with respect to any community mental health center or with respect to any type of service provided by such a center unless a grant with respect thereto was made under this part prior to July 1, 1970.

"PAYMENTS

"SEC. 222. Payment of grants under this part may be made (after necessary adjustment on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

"REGULATIONS

"SEC. 223. The Secretary shall, after consultation with the National Advisory Mental Health Council (appointed pursuant to the Public Health Service Act), prescribe general regulations concerning eligibility of centers under this part, determination of eligible costs with respect to which grants may be made, and the terms and conditions (including those specified in section 221) for approving applications under this part.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 224. There are authorized to be appropriated for each fiscal year beginning after June 30, 1965, such sums as may be necessary to carry out the purposes of this part."

[H.R. 2986, 89th Cong., 1st sess.]

A BILL To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "\$11,000,000" and by inserting "and such sums as may be necessary for each of the next five fiscal years" immediately after "June 30, 1965,". The second sentence of such subsection is amended by striking out "the fiscal years ending June 30, 1963, and June 30, 1964" and inserting in lieu thereof "any fiscal year ending prior to July 1, 1970". The third sentence of such subsection is amended by striking "and tetanus" and inserting in lieu thereof "tetanus, and measles", and by striking out "under the age of five years" and inserting in lieu thereof "of preschool age".

(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future."

(c) Subsection (b) of such section is amended by striking out "of limited duration", by striking out "against poliomyelitis, diphtheria, whooping cough, and tetanus" and inserting in lieu thereof "against the diseases referred to in subsection (a)", and by striking out "who are under the age of five years" and inserting in lieu thereof "of preschool age".

(d) Such section is further amended by striking out "intensive community vaccination" wherever it appears in subsections (a), (b), and (c), and inserting in lieu thereof "immunization".

MIGRATORY WORKERS HEALTH SERVICES

SEC. 3. Section 310 of the Public Health Service Act is amended by striking out "the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965" and inserting in lieu thereof "each fiscal year ending prior to July 1, 1970", and by striking out "any year" and inserting in lieu thereof "any year ending prior to July 1, 1965".

GENERAL PUBLIC HEALTH SERVICES

SEC. 4. The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

[H.R. 2987, 89th Cong., 1st sess.]

A BILL To authorize mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Public Health Service Act (42 U.S.C., ch. 6A) is amended by adding at the end thereof the following new title:

"TITLE IX—GROUP PRACTICE FACILITIES

"DECLARATION OF FINDINGS AND PURPOSE

"SEC. 901. (a) The Congress hereby finds and declares that the group practice of medicine or dentistry offers great promise of improving the quality of medical or dental care, of reducing the occasion for hospitalization and otherwise achieving significant economies to the participating practitioners and to their patients, of contributing, particularly in the smaller communities of the Nation, to a more effective distribution and utilization of physicians, dentists, and other health service personnel in short supply, and of facilitating the establishment, operation, and expansion of voluntary prepayment plans offering comprehensive health services to their members or subscribers. The Congress further finds and declares that lack of the specialized facilities needed and the difficulty of obtaining financing on reasonable terms to construct and equip such facilities constitute major obstacles to the development of group practice.

"(b) It is therefore the purpose of this title to encourage group practice through assurance of the availability of credit on reasonable terms to group practice units or organizations, particularly those in smaller communities and those sponsored by cooperative or other nonprofit organizations, to assist in financing the construction and equipment of group practice facilities.

"MORTGAGE INSURANCE

"SEC. 902. (a) The Surgeon General, on behalf of the United States is authorized, upon application made by the mortgagee in accordance with regulations prescribed by the Surgeon General, to insure any mortgage (including advances on such mortgage during construction) against default in the payment of interest on, and the repayment of the principal of, the obligation secured by the mortgage if the mortgage is for the purpose of financing the construction cost of a group practice facility and meets the conditions hereinafter provided in or prescribed pursuant to this title. The Surgeon General, on behalf of the United States, is also authorized to make commitments, upon such terms as he may prescribe, for the insuring of such mortgages prior to the date of their execution or disbursement thereon.

"(b) No mortgage shall be insured under this title unless the mortgagor is a group practice unit or organization and is approved by the Surgeon General as responsible and able to repay the obligation secured by the mortgage, and the mortgage is made to and held by a mortgagee approved by the Surgeon General as responsible and able to service the mortgage properly, and unless the principal obligation secured by the mortgage—

"(1) is to finance the construction cost of a group practice facility which the Surgeon General finds will be constructed in an economical manner, will not be of elaborate or extravagant design or materials, and will be adequate and suitable for carrying out the purposes of this title;

"(2) does not exceed 90 per centum of the amount which the Surgeon General estimates will be the value of the property or project when construction is completed; for purposes of this clause, the value of the property may, in the Surgeon General's discretion, include the land and the proposed physical improvements (or, in the case of expansion, remodeling, or alteration of existing buildings, the land and all improvements as so expanded, remodeled, or altered), utilities within the boundaries of the property, architects' fees, taxes, and interest accruing during construction, and other miscellaneous charges incident to construction and approved by the Surgeon General;

"(3) has a maturity satisfactory to the Surgeon General but not to exceed twenty-five years and provides for complete amortization of such principal obligation by periodic payments within such term as the Surgeon General shall prescribe;

"(4) bears interest (exclusive of charges made pursuant to section 906(b)) at a rate of not to exceed 5 per centum per annum of the amount of the principal obligation outstanding at any time, or not to exceed such rate (not in excess of 6 per centum per annum) as the Surgeon General finds necessary to meet the mortgage market.

"(c) Any contract of insurance executed by the Surgeon General under this title shall be conclusive evidence of the eligibility of the mortgage for insurance, and the validity of any contract for insurance so executed shall be incontestable in the hands of an approved mortgagee from the date of the execution of such contract, except for fraud or misrepresentation on the part of such approved mortgagee.

"(d) There is hereby established a group practice facilities insurance fund (hereafter in this subsection called the 'fund') which shall be available without fiscal year limitation to the Surgeon General for carrying out the provisions of this section, and the Surgeon General is hereby authorized to transfer to the fund from time to time from the appropriations provided under section 904(a) such sums as he deems necessary to provide capital for the fund. All amounts received by the Surgeon General as premium charges for insurance and as receipts, earnings or proceeds derived from any mortgage or claim or from any other property acquired by the Surgeon General in connection with his operations under this section, or from the disposal of such mortgage, claim, or other property, and any other moneys, property, or assets derived by the Surgeon General from his operations in connection with this section, shall be deposited in the fund. All expenses pursuant to operations under this section shall be paid from the fund, including that portion of the sums authorized from year to year in appropriation Acts to be paid from the fund and the group practice facilities loan fund for administrative expenses under this title which the Surgeon General determines are reasonably allocable to administrative expenses under this section. Moneys in the fund not needed for current operations under this section may be invested in bonds or other obligations guaranteed as to principal and interest by the United States. If at any time the Surgeon General determines that capital surplus and reserves of the fund exceed the present and any reasonably prospective future requirements of the fund, such excess may be deposited in the Treasury as miscellaneous receipts.

"(e) The maximum aggregate amount of insurance liability (contingent or actual) with respect to mortgages insured under this title outstanding at any one time shall not exceed whichever is the lesser of (A) \$200,000,000 less the aggregate principal amount of loans made under section 903 and outstanding at such time, and (B) twenty times the sum transferred to the group practice facilities insurance fund from appropriations under section 904(a) to provide capital for the fund. For the purposes of this subsection, the insurance liability (contingent or actual) with respect to any mortgage insured under this title shall be deemed to be the outstanding principal obligation of the mortgage.

"LOANS

"SEC. 903. (a) To the extent that funds are available therefor, the Surgeon General is authorized to make a loan to any group practice unit or organization to assist in financing the construction cost of a group practice facility if such unit or organization applies therefor in accordance with regulations prescribed by the Surgeon General and if the Surgeon General finds that the applicant is responsible and able to repay the loan but is unable to secure the amount thereof from other sources (with or without mortgage insurance under this title) upon terms and conditions as favorable as the terms and conditions applicable to loans secured by mortgages insurable under section 902. Any such loan shall meet the requirements set forth in clauses (1), (2), and (3) of subsection (b) of section 902, shall bear interest at a rate equal to the maximum rate applicable under clause (4) of such subsection plus the premium charge applicable under section 906(b), and shall be secured in such manner as may be determined by the Surgeon General.

"(b) There is hereby created a group practice facilities loan fund (hereafter in this subsection called the "fund") which shall be available without fiscal year limitation to the Surgeon General for carrying out the provisions of this section, and the Surgeon General, is hereby authorized to transfer to the fund from time to time from the appropriations provided under section 904(a) and available therefor such sums as he deems necessary to provide capital for the fund. All amounts received by the Surgeon General as interest payments or repayments of principal on loans or as earnings or proceeds derived from any mortgage or claim,

or any other property acquired by the Surgeon General in connection with his operations under this section or from the disposal of such mortgage, claim, or other property, and any other moneys, property, or assets derived by the Surgeon General from his operations in connection with this section shall be deposited in the fund. All expenses pursuant to operations under this section shall be paid from the fund, including that portion of the sums authorized from year to year in appropriation Acts to be paid from the fund and the group practice facilities insurance fund for administrative expenses under this title which the Surgeon General determines are reasonably attributable to his operations under this section. Moneys in the fund not needed for current operations under this section may be invested in bonds or other obligations guaranteed as to principal and interest by the United States. Any excess moneys in the fund may be transferred to the group practice facilities insurance fund or, if not needed for such purpose, shall be deposited in the Treasury as miscellaneous receipts.

"(c) The Surgeon General may sell to any person or entity approved for such purpose by him, any loan made under this section and may insure a mortgage securing any loan thus sold under section 902.

"APPROPRIATIONS AND OTHER FINANCING

"SEC. 904. (a) There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this title, except that (1) the aggregate sums authorized to be appropriated shall not exceed \$10,000,000 until June 30, 1966, and thereafter this amount increased by \$12,500,000 on July 1, 1966, and on July 1 of each of the succeeding three years, and (2) not less than 10 per centum of any such appropriation shall be available exclusively for transfer to the group practice facilities insurance fund. Any sums appropriated under this subsection shall remain available until expended. No contract for insurance or loan contract shall be entered into under this title after June 30, 1970, except pursuant to a commitment to insure or lend issued before that date.

"(b) Interest shall accrue to the Treasury on outstanding capital resulting from transfers to the funds established under sections 902 and 903 from appropriations under subsection (a) and shall, for each fiscal year, be determined on the basis of the average daily amount of such capital outstanding during such year. The rate of such interest shall be determined annually in advance by the Secretary of the Treasury taking into consideration the current average yields to maturity (on the basis of daily closing market bid quotations during the month of June of the preceding fiscal year) on outstanding interest-bearing marketable public debt obligations of the United States having maturities comparable to loans secured by mortgages insured under this title, or to loans made under this title, as the case may be. From time to time and at least at the close of each fiscal year, the Surgeon General shall pay to the Treasury, as miscellaneous receipts all accrued interest.

"(c) If at any time the moneys in the group practice facilities insurance fund are insufficient to make payments in connection with the default of any loan insured under this title, the Surgeon General is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions as may be prescribed by the Surgeon General, with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of such notes or other obligations. The Secretary of the Treasury is authorized and directed to purchase any notes and other obligations to be issued hereunder and for such purpose he is authorized to use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, as amended, and the purposes for which securities may be issued under such Act, as amended, are extended to include any purchases of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this subsection. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Funds borrowed under this subsection shall be deposited in the group practice facilities insurance fund and redemption of such notes and obligations shall be made by the Surgeon General from such fund.

"PRIORITIES AND ADVISORY COMMITTEES

"SEC. 905. (a) The Surgeon General shall, pursuant to regulations prescribed by him, establish criteria and procedures for determining priorities in the insuring of mortgages or the making of loans to eligible applicants in the event that the funds available therefor are insufficient to insure or lend in full the amounts requested in applications otherwise approvable, which criteria shall give preference to applications involving facilities to be located in smaller communities and to applications of agencies or organizations described in clause (A) or clause (B) of section 908(4) which are public or nonprofit organizations as defined in section 908(5).

"(b) The Surgeon General, with the approval of the Secretary, may appoint, without regard to the civil service laws, an advisory committee or committees to advise and consult with him with respect to carrying out his functions under this and other provisions of this title. Members of any such advisory committee who are not full-time employees of the United States, shall, while attending meetings or conferences of such committee or otherwise engaged on business of such committee, receive compensation at a rate fixed by the Surgeon General, but not exceeding \$100 per diem, including travel time, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

"PROVISIONS APPLICABLE TO INSURANCE AND LOANS

"SEC. 906. (a)(1) All laborers and mechanics employed by contractors or subcontractors on all construction projects assisted by such insurance or loan will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a-276a-5).

"(2) The Secretary of Labor shall have, with respect to the labor standards specified in clause (1) of this subsection, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-15), and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"(b) The Surgeon General shall fix premium charges for the insurance of mortgages under this title at rates which in his judgment are adequate to cover expenses and probable losses, but such charges shall not be more than one-half of 1 per centum per annum of the amount of the principal obligation of the mortgage outstanding at any time, without taking into account delinquent payments or prepayments. Such premium charges shall be payable by the mortgagee at such times and in such manner as may be prescribed by the Surgeon General.

"(c) Each mortgage insured under this title and each contract for a loan under this title shall contain an undertaking (in accordance with regulations prescribed by the Surgeon General in force at the time the mortgage is approved for insurance or the loan contract is made) to the effect that, except as authorized by the Surgeon General and, in the case of a mortgage, the mortgagee, the property will be used as a group practice facility until the mortgage or loan has been paid in full or the contract of insurance or loan contract otherwise terminated.

"(d) No mortgage shall be insured or loan made under this title unless the mortgagor and the mortgagee, in case of an insured mortgage, and the borrower in the case of a loan, certify (1) that they will keep such records relating to the mortgage or loan transaction and indebtedness, to the construction of the facility covered by the mortgage or loan, and to the use of such facility as a group practice facility as are prescribed by the Surgeon General at the time of such certification, (2) that they will make such reports as may from time to time be required by the Surgeon General pertaining to such matters, and (3) that the Surgeon General or any authorized officer or employee of the Public Health Service or of any agency or institution employed or utilized by the Surgeon General for that purpose, shall have access to and the right to examine and audit such records.

"(e) In the performance of, and with respect to, the functions, powers, and duties vested in him by this title, the Surgeon General may—

"(1) prescribe such regulations as may be necessary to carry out the purposes of this title;

"(2) sue and be sued in any district court of the United States, and such district courts shall have jurisdiction of civil actions arising under this title without regard to the amount in controversy; but no attachment, injunction,

garnishment, or other similar process, mesne or final, shall be issued against the Surgeon General or property under his control, and nothing herein shall be construed to except litigation arising out of activities under this title from the application of sections 507(b) and 2679 of title 28 of the United States Code and of section 367 of the Revised Statutes (5 U.S.C. 316);

"(3) include in any contract for insurance or in any loan contract such terms, conditions, and covenants relating to repayment of principal and payment of interest, relating to his obligations and rights and to those of mortgagees, mortgagors, and borrowers in case of default, and relating to other matters as the Surgeon General determines necessary to assure that the purposes of this title will be achieved, and any terms, condition, and covenant made pursuant to this clause or any other provision of this title may be modified by the Surgeon General if he determines such modification is necessary to protect the financial interest of the United States.

"(4) foreclose on any property or commence any action to protect or enforce any right conferred upon him by any law, contract, or other agreement, and accept assignment of, foreclose on, or bid for and purchase at any foreclosure or any other sale, any real or personal property (tangible or intangible) in connection with which he has insured a mortgage or made a loan pursuant to this title; and, in the event of any such acquisition (and notwithstanding any other provisions of law relating to the acquisition, handling, or disposal of real or personal property by the United States), complete, administer, remodel and convert, sell, exchange, or otherwise dispose of, lease, and otherwise deal with, such property in such manner as he deems appropriate to protect the financial interest of the United States: *Provided*, That no action shall be taken in connection with any such acquisition of real property which would deprive any State or political subdivision thereof of its civil or criminal jurisdiction in and over such property or impair the civil rights under the State or local laws of the inhabitants on such property;

"(5) enter into agreements to pay annual sums in lieu of taxes to any State or local taxing authority with respect to any real property so acquired or owned;

"ADMINISTRATION

"SEC. 907. (a) At the request of individuals or organizations operating or contemplating the operation of group practice facilities, the Surgeon General may provide technical assistance in the planning for and construction of group practice facilities.

"(b) With a view to avoiding unnecessary duplication of existing staffs and facilities of the Federal Government, the Surgeon General is authorized to utilize available services and facilities of any agency of the Federal Government in carrying out the provisions of this title, and to pay for such services and facilities, either in advance or by way of reimbursement, in accordance with an agreement between the Secretary and the head of such agency.

"DEFINITIONS

"SEC. 908. For the purposes of this title:

"(1) The term 'construction cost' means the cost of the construction of a group practice facility, and includes the cost of the erection of new structures and the acquisition, expansion, remodeling, or improvement of existing structures, the cost of necessary acquisition of the land on which the facility is located, and the cost of such equipment as may be permitted in regulations.

"(2) The term 'group practice facility' means a facility in a State for the provision of preventive, diagnostic, and treatment services to ambulatory patients (in which patient care is under the professional supervision of persons licensed to practice medicine in the State or, in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State) and which is primarily for the provision of such health services by a medical or dental group.

"(3) The term 'medical or dental group' means a partnership or other association or group of persons licensed to practice medicine in the State, or of persons licensed to practice dentistry in the State, or of both, who, as their principal professional activity and as a group responsibility, engage or undertake to engage in the coordinated practice of their profession primarily in one or more group practice facilities, and who (in this connection) share common overhead expenses (if and

to the extent such expenses are paid by members of the group), medical and other records, and substantial portions of the equipment and the professional, technical, and administrative staffs, and which partnership or association or group is composed of at least such professional personnel and makes available at least such health services as may be provided in regulations of the Surgeon General.

"(4) The term 'group practice unit or organization' means—

"(A) a private agency or organization (including a medical or dental group) undertaking to provide, directly or through arrangements with a medical or dental group, comprehensive medical care or dental care, or both, which may include hospitalization, to members or subscribers primarily on a group practice prepayment basis;

"(B) a public or private nonprofit agency or organization established for the purpose of improving the availability of medical or dental care in the community or having some function or functions related to the provision of such care, which will, through lease or other arrangement, make the group practice facility with respect to which mortgage insurance or a loan has been requested under this title available to a medical or dental group for use by it; or

"(C) a medical or dental group.

"(5) The term 'nonprofit organization' means a corporation, association, foundation, trust, or other organization no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual except, in the case of an organization the purposes of which include the provision of personal health services to its members or subscribers or their dependents under a plan of such organization for the provision of such services to them (which plan may include the provision of other services or insurance benefits to them), through the provision of such health services (or such other services or insurance benefits) to such members or subscribers or dependents under such plan.

"(6) The term 'State' includes the Commonwealth of Puerto Rico, Guam, the Virgin Islands, American Samoa, and the District of Columbia.

"(7) The term 'mortgage' means a first mortgage (A) on real estate, in fee simple, or (B) on such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Surgeon General finds sufficient to assure undisturbed use and possession for a period of not less than fifty years for the purposes of construction and operation of the group practice facility, and for such concurrent period, not exceeding fifty years, as may be necessary to secure the mortgage debt without regard to the use of the mortgaged property. The term 'first mortgage' means such classes of first liens as are commonly given to secure advances (including but not limited to advances during construction) on, or the unpaid purchase price of, real estate under the laws of the State in which the real estate is located, together with the credit instrument or instruments, if any, secured thereby, and any mortgage may be in the form of one or more trust mortgages or mortgage indentures or deeds of trust, securing notes, bonds, or other credit instruments, and, by the same instrument or by a separate instrument, may create a security interest in initial equipment, whether or not attached to the realty.

"(8) The term 'mortgagee' includes the original lender under a mortgage, and his or its successors and assigns, and includes the holders of credit instruments issued under a trust mortgage or deed of trust pursuant to which such holders act by and through a trustee named therein.

"(9) The term 'mortgagor' includes the original borrower under a mortgage and his or its successors and assigns."

SEC. 2. (a) Section 1 of the Public Health Service Act is amended to read as follows:

"SECTION 1. Titles I to IX, inclusive, of this Act may be cited as the 'Public Health Service Act'."

(b) The Act of July 1, 1944 (58 Stat. 682), as amended, is further amended by renumbering title IX (as in effect prior to the enactment of this Act) as title X and by renumbering sections 901 through 914 (as in effect prior to the enactment of this Act), and references thereto, as sections 1001 through 1014, respectively.

SEC. 3. (a)(1) The sixth sentence of paragraph "Seventh" of section 5136 of the Revised Statutes, as amended (12 U.S.C. 24), is amended by inserting after the words "Federal Home Loan Banks," the following: "or obligations which are insured by the Surgeon General of the Public Health Service under title IX of the Public Health Service Act".

(2) The third sentence of the first paragraph of section 24 of the Federal Reserve Act, as amended (12 U.S.C. 371), is amended by inserting after the words "or sections 1471-1484 of title 42," the following: "or which are insured by the

Surgeon General of the Public Health Service pursuant to title IX of the Public Health Service Act,".

(b)(1) Section 35(4) of chapter III of the Act entitled "An Act to regulate the business of life insurance in the District of Columbia", approved June 19, 1934 (48 Stat. 1125), as amended (D.C. Code, 1961 edition, sec. 35-535), is further amended by inserting after the words "the National Housing Act, as amended," the following: "or insured under the provisions of title IX of the Public Health Service Act,".

(2) Section 18(4) of chapter II of the Act entitled "An Act to provide for the regulation of the business of fire, marine, and casualty insurance, and for other purposes", approved October 9, 1940 (54 Stat. 1063), as amended (D.C. Code, 1961 edition, sec. 35-1321), is further amended to read as follows:

"(4) Bonds or notes secured by mortgages or deeds of trust insured by the Federal Housing Administrator, or insured under the provisions of title IX of the Public Health Service Act, or in debentures issued by the Federal Housing Administrator: *Provided*, That the restrictions in subparagraph (3) of this section in regard to the ratio of the loan to the value of the property shall not apply to such insured mortgages or deeds of trust."

(c) Subsection (a) of section 304 of the Trust Indenture Act of 1939 (15 U.S.C. 77ddd) is amended by striking out the word "or" at the end of subparagraph (8); by striking out the period at the end of subparagraph (9) and inserting in lieu thereof a semicolon and the word "or"; and by adding after subparagraph (9), a new subparagraph as follows:

"(10) any security issued under a mortgage or trust deed indenture as to which a contract of insurance under title IX of the Public Health Service Act is in effect; and any such security shall be deemed to be exempt from the provisions of the Securities Act of 1933 to the same extent as though such security were specifically enumerated in section 3(a)(2), as amended, of the Securities Act of 1933 (15 U.S.C. 77e(a)(2))."

(d) Section 263 of chapter X of the Bankruptcy Act (11 U.S.C. 663) is amended by adding at the end thereof the following: "Nothing contained in this chapter shall be deemed to affect or apply to the creditors of any corporation under a mortgage insured pursuant to title IX of the Public Health Service Act.".

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., March 8, 1965.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your requests for views of the Bureau of the Budget on H.R. 2984, a bill to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes; H.R. 2985, a bill to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers; H.R. 2986, a bill to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes; and H.R. 2987, a bill to authorize mortgage insurance loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry.

H.R. 2984 carries out the President's recommendation contained in his health message to the Congress that the authority to assist in the construction of health research facilities be increased and extended for 5 years with provision for a larger Federal share for specialized research facilities of a national or regional character. The bill also includes new authority for research contracts and would create three additional Assistant Secretaries in the Department of Health, Education, and Welfare.

The Nation's first major step to provide improved community care for the mentally ill was passage of the community mental health facilities construction legislation by the last Congress. However, partial support of operating costs is required if the full benefit of a community-oriented care is to be reached. Few communities have the funds to provide full support of adequate services during the initial stages of operations. Many communities with the greatest need will not be able to participate without the type of support authorized in H.R. 2985.

H.R. 2986 provides for extension through fiscal year 1970 of the existing Public Health Service community vaccination and migratory agricultural workers health programs. The vaccination program would be expanded to provide protection against measles and such other infectious diseases which the Surgeon General finds to be a major health problem. This legislation also proposes a 1-year extension of the general health grant and special project grants for improving community health services for which the authorization expires at the close of fiscal year 1966.

The President, in his health message, recommended aid to group practice facilities as needed to secure the greatest utilization of the available supply of doctors and dentists and to provide a wide range of out-of-hospital services. Such support is contained in H.R. 2987 which authorizes the Surgeon General to insure mortgage-secured loans for the construction of group practice facilities and to make direct loans if he finds that the applicant is unable to secure financing from other sources.

All four bills are important parts of, and in accord with, the President's health program for the Nation.

Sincerely yours,

PHILLIP S. HUGHES,
Assistant Director for Legislative Reference.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 2, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of February 15, 1965, for a report on H.R. 2984, a bill to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes. The bill has the short title "Health Research Facilities Amendments of 1965."

H.R. 2984 would carry out the President's recommendation, contained in his health message of January 7, 1965, that the authority of the Surgeon General of the Public Health Service to assist in the construction of health research facilities construction "be extended for 5 years with an increased authorization and with a larger Federal share for specialized research facilities of a national or regional character." It also would facilitate research contracts by writing into the basic provisions of the Public Health Service Act relating to research (i.e., sec. 301), the authority, now carried in annual appropriation acts, to enter into such contracts and, when appropriate, to include in such contracts provisions for the indemnification of contractors as now authorized in the case of the military departments by 10 U.S.C. 2354. In addition, the proposal would make available to the Surgeon General the flexible authority of military departments under 10 U.S.C. 2353 to include in a research contract, when necessary for the performance of the contract, provisions for the construction of facilities; such authority was included in our fiscal year 1965 Appropriation Act (Public Law 88-605) with respect to special cancer research.

A further important feature of H.R. 2984 is contained in section 4 which would establish in this Department three positions of Assistant Secretary of Health, Education, and Welfare (to be appointed by the President with the advice and consent of the Senate). This section is identical (except for some technical and conforming changes) with this Department's proposal included in H.R. 6360 which you introduced in the 88th Congress. We strongly urge enactment of this legislation. Inasmuch as we are scheduled to testify before your committee on this bill on Tuesday, March 2, we shall not burden this report with a detailed justification of its provisions. We are, however, enclosing for your convenience a section-by-section analysis of the bill.

Sincerely,

WILBUR J. COHEN,
Assistant Secretary.

Enclosure.

SECTION-BY-SECTION ANALYSIS OF H.R. 2984

SECTION 1

This section provides that this legislation may be cited as the Health Research Facilities Amendments of 1965.

SECTION 2

This section amends section 704 of the Public Health Service Act to extend for 5 additional years the authorization for grants-in-aid for the construction of facilities for research, or research and related purposes, in the health-related sciences under part A of title VII of such act. The annual appropriations authorization of \$50 million expires June 30, 1966, and the bill would authorize appropriations not to exceed an aggregate of \$400 million for the 5 fiscal years from 1967 through 1971.

Section 2(b) of the bill extends from June 30, 1965, to June 30, 1970, the date by which applications for grants under title VII-A must be received.

Section 2(c) adds to the Public Health Service Act a new section 712. Subsection (a) of the new section would authorize the Surgeon General to construct or make arrangements for constructing, through contracts for paying all or part of the cost of construction or otherwise, facilities for the conduct of research, or for research and related purposes, in the health-related sciences when he finds, in accordance with regulations approved by the Secretary of Health, Education, and Welfare, that the purposes of title VII-A can best be achieved through the construction of national or regional health research facilities or that a grant pursuant to the other provisions of part A of title VII does not provide an effective or appropriate means of financing such facilities. The Surgeon General would also be authorized to arrange, by contract or otherwise, for the operation of such facilities and could make contributions toward the cost of operation of health-research facilities whether or not constructed with aid under the new section. The Surgeon General could transfer title to any facility constructed under such section to any competent public or nonprofit private institution, subject to the condition that the facility will be operated for research and related purposes, and to such other conditions as the Surgeon General deems necessary to carry out the objectives of the health research facilities program and to protect the interests of the United States. The prevailing wage provisions of the Davis-Bacon Act would be applicable to construction of health research facilities under such section.

Subsection (b) of the new section 712 authorizes the appropriation of such sums as may be necessary for fiscal years from 1966 through 1971 for carrying out this section, and sums appropriated for construction under the section would remain available until expended.

Subsection (d) of section 2 of the bill amends section 707 of the Public Health Service Act, which provides for recapture of payments if the applicant or other owner of the facility ceases to be a public or nonprofit institution, or the facility ceases to be used for the research and related purposes for which it was constructed, by making that provision applicable only to facilities which have received grants. (With respect to facilities assisted by contract or otherwise, the proposed new subsection 712 authorizes transfer of title to a facility subject to necessary conditions to assure that it will be used for research purposes.)

SECTION 3

This section amends section 301 of the Public Health Service Act to authorize the Surgeon General to enter into contracts, including contracts for research, in accordance with and subject to the provisions of law applicable to contracts for research entered into by the military departments under title 10, United States Code 2353 and 2354, except that the Secretary of Health, Education, and Welfare would take the actions required of the Secretary concerned under those sections. Section 2353 of title 10, United States Code, authorizes contracts for the construction of specialized facilities for research, and section 2354 authorizes inclusion in research contracts of provisions for the indemnification of contractors for liabilities for injuries or damage to property sustained by third parties resulting from risks that the contract defines as unusually hazardous.

SECTION 4

Subsection (a) of this section provides for three additional Assistant Secretaries of Health, Education, and Welfare.

Subsection (b) abolishes the Office of Special Assistant to the Secretary (Health and Medical Affairs).

Subsection (c) amends section 303 of the Federal Executive Salary Act of 1964 to authorize five instead of two, Assistant Secretaries of Health, Education, and Welfare in level III of the Executive Salary Schedule, and deletes the listing of the Special Assistant to the Secretary (Health and Medical Affairs) in level V of such schedule.

Subsection (d) provides that the President may authorize the person who immediately prior to the date of enactment of this legislation occupies the Office of Special Assistant to the Secretary (Health and Medical Affairs) to act as one of the additional Assistant Secretaries authorized by subsection (a) of this section until the President appoints and the Senate confirms an appointment to that office. Such person would receive the compensation of an Assistant Secretary.

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, D.C., March 9, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in further response to your requests for our views on H.R. 2984, Health Research Facilities Amendments of 1965; H.R. 2985, Community Mental Health Centers Act Amendments of 1965; H.R. 2986, Community Health Services Extension Amendments of 1965; and H.R. 2987, mortgage insurance and loans for group practice of medicine and dentistry.

We strongly favor the enactment of these proposals which will implement the President's recommendations in his recent health message regarding the expansion and improvement of the Nation's health services and facilities. We believe that the proposed legislation will contribute significantly to elevation of our national health standards.

The Bureau of the Budget advises that there is no objection to the submission of this report from the standpoint of the administration's program.

Sincerely,

W. WILLARD WIRTZ,
Secretary of Labor.

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C., March 2, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Rayburn Office Building.*

DEAR MR. CHAIRMAN: This is in further response to your request of February 15, 1965, for a report on H.R. 2984, "To amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes."

The Commission fully supports the objectives of this bill and recommends that it be given favorable consideration.

Our primary interest is in section 4 which provides three additional Assistant Secretary positions in the Department of Health, Education, and Welfare. Two of these will be new positions; the third will be for the conversion of the existing position of Special Assistant to the Secretary (Health and Medical Affairs) which will be abolished. The bill includes appropriate amendments to place the three positions in level IV of the Federal executive salary schedule along with other assistant secretaries of executive departments.

Since its establishment in 1953, the Department has been under the direction of a Secretary, an Under Secretary, two Assistant Secretaries, and a Special Assistant to the Secretary (Health and Medical Affairs) who functioned at the assistant secretary level. During the past years the number of the Department's programs has more than tripled and many of these are continuing to be expanded. The annual appropriations and employment in the Department have been increased between 9 and 10 times their original size. This growth in activities and responsibilities has created a need for additional executive direction and supervision which cannot be provided by the number of high level executives now authorized for the Department.

The assistant secretary positions created by H.R. 2984 are intended to provide the much needed additional executive leadership that will enable the Secretary of Health, Education, and Welfare to carry on the programs of his Department more effectively and efficiently.

The Bureau of the Budget advises that from the standpoint of the administration's program there is no objection to the submission of this report.

By direction of the Commission:

Sincerely yours,

JOHN W. MACY, Jr., *Chairman.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 2, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives,
Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of February 15, 1965, for a report on H.R. 2985, a bill "To authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers." The bill carries the short title of the "Community Mental Health Centers Act Amendments of 1965."

As you know, H.R. 2985 is the administration's legislative proposal to carry out one of the recommendations made by the President in his Health Message of January 7, 1965. We strongly urge enactment of this bill.

Inasmuch as we are scheduled to testify on this bill on Tuesday, March 2, we are not detailing the need for it in this report. We are, however, enclosing a section-by-section analysis of the bill for your convenience.

Sincerely,

WILBUR J. COHEN, *Assistant Secretary.*

Enclosure.

SECTION-BY-SECTION ANALYSIS OF H.R. 2985

SECTION 1

This section provides that this legislation may be cited as the "Community Mental Health Centers Act Amendments of 1965."

SECTION 2

Section 2 of the bill proposes to amend the Mental Retardation Facilities and Community Mental Health Centers Construction Act (Public Law 88-164) by changing the heading of title II of that act to read "Title I—Community Mental Health Centers", by inserting subheading "Part A—Grants for Construction of Centers", and by inserting a new "Part B—Grants for Initial Cost of Professional and Technical Personnel of Centers".

Section 220 (a) under new part B would authorize the Secretary of Health, Education, and Welfare to make grants to assist in meeting a portion of the costs (to be determined by regulation) of compensating professional and technical personnel for the initial operation of new community mental health centers or of new services in existing community mental health centers.

Subsection (b) of the new section would provide that such grants may be made only for a temporary period, beginning with the first month for which such a grant is made and ending with the close of 4 years and 3 months after such month. The amount of any such grant could not exceed 75 percent of the portion of costs (determined by regulation) for the period ending with the close of the 15th month following the 1st month, 60 percent for the 1st year thereafter, 45 percent for the 2d year, and 30 percent for the 3d year thereafter.

New section 221(a) would establish the conditions for approving applications for grants under part B, to the effect that an applicant (1) must be a public or nonprofit private agency or organization which owns or operates the center; (2) service to be provided by the center (alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant) will be part of a program providing, principally for persons residing in a particular community or communities in which or near where the center is situated, at least those essential elements of comprehensive mental health services which are prescribed by the Secretary, and (3) a grant was made under part A of title II

to assist in financing construction of the center, or the type of service to be provided as part of such program by such center with the aid of a grant under this part was not previously being provided.

Subsection (b) of section 221 would provide that no grant may be made after June 30, 1970, with respect to any community mental health center or with respect to any type of service provided by such a center under a grant with respect thereto was made under this part prior to July 1, 1970.

Section 222 would provide that payments of grants may be made (after adjustment on account of previously made overpayments or underpayments) in advance or by way of reimbursement and on such terms and conditions and in such installments, as the Secretary may determine.

Section 223 would authorize the Secretary to prescribe general regulations after consultation with the National Advisory Mental Health Council, concerning eligibility, eligible costs and the terms and conditions for approving applications.

Section 224 would authorize the appropriation of such sums as may be necessary for each fiscal year beginning after June 30, 1965.

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C., March 4, 1965.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives,
Rayburn House Office Building.

DEAR MR. CHAIRMAN: This is in further reply to your request of February 15, 1965, for the views of the Civil Service Commission on H.R. 2985, a bill "To authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers."

Although this bill is concerned with matters outside the jurisdiction of the Civil Service Commission and we have no comment to offer on its specific provisions, the Commission strongly supports the overall purposes and objectives of the bill.

The Bureau of the Budget advises that from the standpoint of the administration's program there is no objection to the submission of this report.

By direction of the Commission.

Sincerely yours,

JOHN W. MACY, Jr., *Chairman.*

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., March 15, 1965.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

DEAR MR. CHAIRMAN: By letter dated February 15, 1965, you requested our comments on H.R. 2985. The stated purpose of this measure is to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers.

While we have no special information that would assist the committee in its consideration of the merits of H.R. 2985, we would like to offer the following comment.

No provision is made in H.R. 2985 nor in legislation applicable to other grant programs now authorized by the Public Health Service Act, as amended, 42 U.S.C. 201 et seq.—with the exception of the hospital programs under title VI thereof—to require a grantee to keep adequate cost records of the projects to which the Federal Government makes financial contributions, or specifically authorizing the Secretary of Health, Education, and Welfare or the Comptroller General to have access to the grantee's records for purposes of audit and examination. In view of the increase in grant programs over the last several years, we feel that in order to determine whether grant funds have been expended for the purpose for which the grant was made, the grantee should be required by law to keep records which fully disclose the disposition of such funds. We also feel that the agency as well as the General Accounting Office should be permitted to have access to the grantee's records for the purpose of audit and examination. We therefore suggest that consideration be given to amending the bill to include such requirements with respect to the proposed new grant program, or preferably to an amendment of the Public Health Service Act to cover all grant programs therein authorized. The latter could be accomplished by the following language:

"RECORDS AND AUDIT

"(a) Each recipient of assistance under this Act shall keep such records as the Surgeon General shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grants, the total cost of the project or undertaking in connection with which such funds are given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the grants received under this Act."

Language similar to that suggested above is contained in section 11 of the Clean Air Act, approved December 17, 1963, Public Law 88-206, 77 Stat. 401, the act of May 31, 1962, Public Law 87-460, 76 Stat. 83, and in section 25 of the Area Redevelopment Act, approved May 1, 1961, Public Law 87-27, 75 Stat. 63, 42 U.S.C. 2522 (supp. V).

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 2, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of February 15, 1965, for a report on H.R. 2986, a bill "To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health service, and for other purposes." The proposal would be cited as the "Community Health Services Extension Amendments of 1965."

H.R. 2986 is the administration's proposal to implement one of the President's recommendations contained in his health message of January 7, 1965. We strongly recommend its enactment.

Inasmuch as we are scheduled to testify on this bill on Tuesday, March 2, we shall not burden this report with a detailed justification of its provisions. We are, however, enclosing for your convenience a section-by-section analysis of the bill.

Sincerely,

WILBUR J. COHEN, *Assistant Secretary.*

Enclosure.

SECTION-BY-SECTION ANALYSIS OF H.R. 2986

SECTION 1

This section of the bill provides that this legislation may be cited as the "Community Health Services Extension Amendments of 1965."

SECTION 2

Subsection (a) of section 2 of the bill would amend subsection (a) of section 317 of the Public Health Service Act to extend for 5 additional years the authority (which expires June 30, 1965) to make grants to States, and political subdivisions and instrumentalities approved by State health authorities, to pay the cost of vaccines and administrative expenses of immunization programs against poliomyelitis, diphtheria, whooping cough, and tetanus, and the bill would make immunization programs against measles eligible for such assistance. The existing provisions authorized appropriations of \$14 million for fiscal year 1963, and \$11 million for each of the fiscal years 1964 and 1965. The bill would authorize such sums as may be necessary for the next 5 fiscal years. As under the existing provision, amounts appropriated for a fiscal year would be available for making grants during the fiscal year for which appropriated and the succeeding fiscal year. Under the bill, grants would cover the cost of purchasing vaccines needed to protect children "of preschool age," instead of "under the age of 5 years," as present law provides.

Section 2(b) of the bill would add to section 317(a) of the Public Health Service Act authority to assist immunization programs against any other infectious disease which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future.

Section 2(c) of the bill would amend subsection (b) of section 317 of the Public Health Service Act by deleting the qualification that immunization programs be "of limited duration" and makes technical amendments to conform to changes made in subsection (a) of section 317.

Section 2(d) of the bill changes all references to "intensive community vaccination programs," in section 317 (a), (b), and (c), to "immunization programs."

SECTION 3

This section extends for 5 additional years the authority of the Surgeon General (expiring June 30, 1965) under section 310 of the Public Health Service Act to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of family health service clinics and special health projects for domestic agricultural migratory workers and their families. Appropriations of up to \$3 million were authorized for fiscal years 1963, 1964, and 1965, and the bill would authorize such sums as may be necessary for the next 5 fiscal years.

SECTION 4

This section extends for 1 additional year section 314(c) of the Public Health Service Act (expiring June 30, 1966), which authorizes annual appropriations of \$50 million to assist States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public health services, including demonstration and training grants and including \$2,500,000 for grants-in-aid to schools of public health.

SECTION 5

This section extends for 1 additional year section 316 of the Public Health Service Act (expiring June 30, 1966), which authorizes annual appropriations of \$10 million for grants to State or other public or nonprofit private agencies or organizations for studies, experiments, and demonstrations looking toward development of new or improved methods of providing community health services outside the hospital, particularly for chronically ill or aged persons.

DEPARTMENT OF AGRICULTURE,
Washington, D.C., March 24, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in reply to your request of February 22, for our views on H.R. 2986, a bill "To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes."

This Department favors this bill and recommends that it be passed.

The bill slightly amends and extends certain provisions of several sections of the Public Health Service Act (as amended by various public laws in 1961 and 1962). Provisions relating to grants for intensive vaccination programs and to grants for family health service clinics for domestic agricultural migratory workers are extended through June 30, 1970. Provisions regarding general public health services and special project grants for community health services are extended for 1 additional year beyond the original time period of the act, or in effect through June 30, 1967.

We believe that the programs included under these sections are greatly in the public interest and that provisions for their continuance as provided for by H.R. 2986 are essential. We are particularly concerned that steps already taken to improve the health services available to migratory workers be continued and extended to geographical areas which still offer inadequate services.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

CHARLES S. MURPHY, *Under Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 2, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of February 15, 1965, for a report on H.R. 2987, a bill "To authorize mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry."

This bill is the administration's proposal to carry out the President's recommendation for legislation on this subject contained in his health message of January 7, 1965. We accordingly urge enactment of H.R. 2987.

Since we are scheduled to testify on this bill on Tuesday, March 2, we shall not detail in this report the reasons which we believe justify enactment of the proposal. We are, however, enclosing for your convenience a summary explanation of the bill.

Sincerely,

WILBUR J. COHEN,
Assistant Secretary.

Enclosure.

SUMMARY EXPLANATION OF H.R. 2987 (89TH CONG., 1ST SESS.)—GROUP PRACTICE
FACILITIES BILL

Group practice units or organizations aided under the bill would be of three types—first, cooperative or other organizations (including medical or dental groups) which provide comprehensive medical or dental care, or both, on a group practice prepayment basis to their members or subscribers; second, public or nonprofit organizations, established for the purpose of improving the availability of medical or dental care in the community, which will make group practice facilities available to medical or dental groups for their use; and third, medical or dental groups. The bill defines a medical or dental group as an association of persons licensed to practice medicine or dentistry, or both, who as their principal professional activity and as a group responsibility, engage in the coordinated practice of their profession primarily in one or more group practice facilities; such a group must share common overhead expenses, medical and other records, and substantial portions of the equipment and professional, technical, and administrative staffs, and must be composed of at least such professional personnel and make available at least such health services as are prescribed by regulation of the Surgeon General.

Group practice facilities, the construction, improvement, or acquisition of which could be financed through mortgage insurance or loans under the bill, are defined as facilities for the provision of preventive, diagnostic, and treatment services to ambulatory patients, primarily through a medical or dental group.

H.R. 2987 would authorize the Surgeon General of the Public Health Service to insure mortgages securing loans for the construction of group practice facilities, up to a maximum aggregate liability of \$200 million outstanding at any one time. This \$200 million maximum would, however, be reduced by the amount of any outstanding direct loans made for such construction. Also, the bill limits the aggregate liability which may be incurred under the mortgage insurance program to 20 times the amounts appropriated and transferred to provide capital for the mortgage insurance fund, principally as reserves against possible losses.

To be insurable, the loan secured by the mortgage must not exceed 90 percent of the estimated value of the project when constructed, must have a maturity of 25 years or less, must bear interest at or below the 5-percent maximum specified in the bill, or at or below a higher maximum (which cannot exceed 6 percent) which the Surgeon General could establish if he found the higher maximum necessary to meet the mortgage market. In consideration for the Government insurance the mortgagee (or the borrower) would be required to pay a premium charge fixed by the Surgeon General at a rate adequate to cover expenses and

probable losses; this premium charge could in no case exceed one-half of 1 percent of the loan secured by the mortgage and outstanding at the time.

The proposal contains provisions designed to assure that the group practice facility constructed with the aid of mortgage insurance would be constructed in an economical manner and would be adequate and suitable for carrying out the purposes of the program. The usual labor standards—payment of prevailing wages and provision for overtime pay for work in excess of 8 hours a workday or 40 hours a workweek—would be applicable. Various powers essential to the efficient administration of such a program, and customarily conferred upon Federal agencies administering similar programs, would be conferred upon the Surgeon General for purposes of both the mortgage insurance and direct loan program. The bill also contains amendments to various Federal laws applicable to banking or other investing institutions operated or regulated by the Federal or District of Columbia Governments, and an amendment to the Bankruptcy Act, which amendments would accord the same status to loans secured by mortgages insured under the bill as is accorded loans secured under other Federal loan insurance programs.

Direct loans are authorized to be made to assist in the construction of group practice facilities only if the Surgeon General finds that the applicant is unable to borrow the amount of the loan from other sources, with or without mortgage insurance, upon terms and conditions generally as favorable as the terms and conditions applicable to loans secured by mortgages insurable under the mortgage insurance program. The terms and conditions applicable to direct loans parallel those applicable under the insurance program, and the interest rate payable on direct Federal loans would be that applicable on loans secured by insured mortgages plus an amount equivalent to the premium charged for the Government insurance.

The mortgage insurance and direct loan programs would operate on a self-financing basis. Reference has already been made to the premium charges for mortgage insurance (and the corresponding increment in the interest rate on direct loans) and to the limitation on the amount of mortgage insurance liability that can be incurred, which limitation is designed to provide reserve capital to meet losses under the insurance program at a ratio of \$1 in reserve to each \$20 of insurance liability. In addition, the bill contains provisions for repayment to the Treasury of amounts appropriated and used to provide capital for the mortgage insurance program (principally as reserves) and for direct loans, and for payment of interest to the Treasury at a rate representing the interest cost to the Government on all appropriations thus used until they are repaid. For this purpose the bill established two funds, one for the mortgage insurance program and one for the loan program so that the current financial status of each program can be ascertained at any time. Finally, all expenses of the Surgeon General for administration of the program are paid out of these funds.

To provide full assurance to mortgages that adequate Federal funds will be available to meet promptly their claims under mortgage insurance contracts in the event of defaults on the part of borrowers, the bill authorizes the Surgeon General to borrow from the Treasury the amounts he needs to pay such claims if at the time the moneys in the mortgage insurance fund are insufficient to pay them in full; amounts so borrowed also bear interest until repaid to the Treasury.

Appropriations of up to \$10 million would be authorized for the fiscal year 1966 to provide capital for the mortgage insurance and loan funds. The ceiling on appropriations authorized for this purpose would be increased by \$12,500,000 at the beginning of fiscal year 1967, and by a like amount at the beginning of each of the next 3 fiscal years, so that during the fifth year the aggregate appropriations authorized would be \$60 million. The bill specifically limits the making of new insurance contracts or new loans to the 5 fiscal year period, beginning with the fiscal year 1966 and ending with the fiscal year 1970.

Amounts appropriated would be used either for mortgage insurance or direct loans, as the expected demand for each indicated, except that at least 10 percent of any appropriation could be used only for mortgage insurance. Assuming, as is anticipated, that most group practice facility projects would be privately financed through the mortgage insurance program, only a portion of the maximum appropriation authorization would be utilized; thus, with the reserve-to-liability ratio of 20 to 1 contemplated under the mortgage insurance provisions of the bill, only \$10 million in appropriations would be needed as reserves for the maximum \$200 million in insurance liabilities authorized to be incurred.

In the event that the aggregate appropriations and other funds available at any time were insufficient to insure or lend in full the amounts requested in approvable applications, the Surgeon General would, by regulation, establish a system of

priorities under which preference would be given to projects for group practice facilities to be constructed in smaller communities, to cooperative or other non-profit applicants which provide comprehensive health services to their members on a group practice prepayment basis, and to public or nonprofit organizations which would make the facility available for group practice units as a community service.

Responsibility for the administration of the program would be vested in the Surgeon General of the Public Health Service and the bill authorizes him to appoint an advisory committee or committees to advise him in carrying out his functions. The Surgeon General could also utilize other Federal agencies to aid in the administration of the program, and thus avoid duplication of the existing staffs and facilities of such agencies. He would be authorized, in addition, to provide technical assistance in the planning and construction of group practice facilities when requested to do so by persons or organizations operating or contemplating the operation of such facilities.

HOUSING AND HOME FINANCE AGENCY,
OFFICE OF THE ADMINISTRATOR,
Washington, D.C., March 5, 1965.

Subject: H.R. 2987, 89th Congress (Representative Harris).

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to your recent letter requesting the views of this Agency on H.R. 2987, a bill to authorize mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry.

This bill would authorize the Surgeon General to insure mortgages equal to 90 percent of the cost of the construction of medical and dental group-practice facilities. Insured mortgages could not have maturities which exceed 25 years and could bear interest at a rate the Surgeon General finds necessary to meet the mortgage market, but not in excess of 6 per centum per annum. Premium charges for the insurance of mortgages would be fixed by the Surgeon General at rates in his judgment adequate to cover expenses and probable losses, but not in excess of one-half of 1 per centum per annum of the amount of outstanding principal of the mortgage. If the Surgeon General finds that an applicant is unable to secure an insured loan, he could make a direct loan upon terms and conditions as favorable as those provided for insured loans.

In his January 7, 1965, message to the Congress concerning the Nation's health, President Johnson pointed out that the "growth of voluntary, comprehensive group-practice programs has demonstrated the feasibility of grouping health services for the mutual benefit of physicians and patients."

The difficulty of obtaining financing for group-practice facilities is often a major obstacle in their development. In order to encourage the establishment of medical and dental group-practice facilities, President Johnson recommended legislation to authorize a program of Federal mortgage insurance and, where necessary, direct loans to finance these facilities.

H.R. 2987 would implement these recommendations of the President, and the Housing Agency recommends its enactment.

The Bureau of the Budget has advised that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ROBERT C. WEAVER, *Administrator.*

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., March 18, 1965.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

DEAR MR. CHAIRMAN: Your letter of February 15, 1965, requests our comments on H.R. 2987, to authorize mortgage insurance loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry.

The bill would amend the Public Health Service Act by adding to it a new title IX. The stated purpose thereof is to encourage the group practice of medicine and dentistry through assurance of the availability of credit on reasonable terms to such group-practice units or organizations, particularly those in smaller communities and those sponsored by cooperative or other nonprofit organizations, to assist in financing the construction and equipment of group-practice facilities. We have no special information as to the desirability of the proposed legislation; and, consequently, we have no recommendations to make on its merits. We do, however, have some comments which we offer for consideration of your committee.

Section 902 would establish a group-practice-facilities revolving insurance fund for use by the Surgeon General to insure under certain terms and conditions, on behalf of the United States, upon the application of the mortgagee, any mortgage, including advances on such mortgage during construction, against default by the mortgagor in the payment of interest and principal on the obligation secured by the mortgage covering such facilities. The aggregate amount of insurance liability could not exceed \$200 million or such lesser amount as provided for therein.

Section 903 would establish a group-practice-facilities revolving loan fund for use by the Surgeon General to make loans under certain terms and conditions, within the limit of available funds, to any group practice unit or organization to assist in financing the construction cost of a group-practice facility if he finds that the applicant is responsible and able to repay the loan but is unable to secure the amount thereof from other sources (with or without mortgage insurance under this title) upon terms and conditions as favorable as the terms and conditions applicable to loans secured by mortgages insurable under section 902.

Financing of the group-practice facilities insurance and loan programs would be accomplished through capitalizing both revolving funds with appropriations authorized in section 904, and deposits into the respective revolving funds of all receipts and earnings derived from the operations incident to such programs. Any excess moneys in the revolving loan fund may be transferred under authority of section 903(b), to the revolving insurance fund. In addition, provision is made in section 904(c) for borrowing from the Treasury through public debt transactions in the event sufficient funds are not available in the revolving insurance fund to meet its obligations in connection with the default of insured mortgage loans. All expenses in connection with operations of the insurance and loan programs are to be paid from the applicable revolving fund.

We are not aware of any tangible benefits which would result from the establishment and use of revolving funds to finance the group-practice facilities insurance and loan programs. Generally, the financing of programs by revolving funds rather than by the usual appropriation procedure tends to lessen congressional control over such programs. The normal revolving fund as defined in our regulations (2 GAO 1235.30b and 7 GAO 1020.75), and in section 21 of Bureau of the Budget Circular No. A-34 are based on the concept that a revolving fund does not require annual congressional authorization. It is our view that the budgetary and appropriation processes followed in financing activities through annual appropriations provide the best means for effective congressional control and that the need for departure from this process should be clearly demonstrated.

In addition, section 904(c) authorizes the Surgeon General to issue notes or other obligations for purchase by the Secretary of the Treasury, if the funds in the insurance revolving fund are insufficient to make payments on account of default of any insured loan. The Secretary of the Treasury is authorized to use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, as amended.

Authorizations to finance programs and activities through public debt transactions are usually stated in terms of maximum amounts of obligations in the Treasury which can be outstanding at any one time with no annual limitation. The authorizations are contained in substantive legislation originated in legislative committees instead of appropriation legislation reviewed by the Appropriation Committees. The continuing feature of these authorizations avoids the need for annual appropriations, and thus there is less compulsion for careful evaluation by successive Congresses of the need for continuing particular programs. We believe that the financing of defaulted insured mortgage loans through public debt transactions, by combining program authority with funding, tends to perpetuate such a program and that it might not otherwise stand the test of recurring congressional review. The General Accounting Office has for many years stated objections to this method of financing and recommends that funds to finance such activities should be made available to the agency responsible for administering

them through the normal annual budgetary and appropriation processes rather than under authorizations to finance through public debt transactions.

However, if use of the revolving funds and public debt financing is to receive favorable consideration, it is suggested, to reserve congressional control over the activities of the insurance and loan programs, that the period on lines 5 and 19 of pages 6 and 8 of the bill, respectively, be changed to a comma and that after the word "section" there be added "when so provided in annual appropriation acts and within such limitations as may be included in appropriation acts." Also, the language, "that portion of the sums authorized from year to year in appropriation Acts to be paid from the fund and the group practice facilities loan fund for" appearing in line 24, page 5, lines 1, 2, and 3, page 6, and in lines 14, 15, and 16, page 8, should be deleted.

As previously stated, section 903(b) would permit the transfer of excess money in the loan fund to the insurance fund. Such transfers would appear to defeat the purpose of two separate funds. If the revolving fund provisions are retained, consideration should be given to either establishing a single fund for both activities or eliminating the authority for transfers between the funds. Also, if revolving fund provisions are retained in either a single fund for both activities or in two separate funds, we feel that it should be made mandatory that all excess funds be deposited in the Treasury as miscellaneous receipts. In this regard, compare the mandatory language applicable to such deposits of excess loan funds in section 903(b) with the permissive language regarding such deposits from the insurance fund in section 902(d).

The parenthetical phrase in section 903(a) "with or without mortgage insurance under this title" should be clarified, since it would appear to permit the Surgeon General to make loans without regard to whether applicants could obtain an insured loan from other sources.

Section 906(d) requires maintenance of records relating to mortgage or loan transaction and indebtedness, to the construction of the facility, to the use of such facility, and it provides for access to such records by the Surgeon General. However, no provision is included for access to such records by the Secretary of Health, Education, and Welfare and the Comptroller General. We suggest that appropriate language be included in the bill which would authorize such access by these officials for purposes of audit and examination.

Section 907(b) would authorize the Surgeon General to utilize available services and facilities of any agency of the Federal Government in carrying out the provisions of the bill, with a view to avoiding unnecessary duplication of existing staffs and facilities of the Federal Government. We believe that this provision should be revised to specifically require that, with the exception of such matters as loan and mortgage insurance approvals, the administration of the programs shall be performed by an agency already engaged in the operation of loan and loan guarantee programs.

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

GOVERNMENT OF THE DISTRICT OF COLUMBIA,
Washington, D.C., March 1, 1965.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

DEAR MR. HARRIS: The Commissioners of the District of Columbia have for report H.R. 2987, 89th Congress, a bill to authorize mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry.

The Commissioners are of the view that the bill will operate to encourage the private construction of facilities for the group practice of medicine or dentistry. Accordingly, they recommend its enactment.

The Commissioners have been advised by the Bureau of the Budget that, from the standpoint of the administration's program, there is no objection to the submission of this report to the Congress.

Sincerely yours,

WALTER N. TOBRINER,
President, Board of Commissioners, District of Columbia.

The CHAIRMAN. We are very glad this morning to have with us for the first time in this new Congress the distinguished Secretary of Health, Education, and Welfare, who comes to us in the interest of these programs.

Mr. Secretary, we welcome you and your colleagues. We will be glad to have your comments on these important programs.

STATEMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. EDWARD W. DEMPSEY, SPECIAL ASSISTANT TO THE SECRETARY, HEALTH AND MEDICAL AFFAIRS; DR. STANLEY F. YOLLES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; AND DR. LUTHER L. TERRY, SURGEON GENERAL, PUBLIC HEALTH SERVICE

Secretary CELEBREZZE. Mr. Chairman and distinguished members of the committee, I have with me to my far left Dr. Luther Terry, the Surgeon General of the Public Health Service; next to me, on my left, Dr. Edward Dempsey, Special Assistant to the Secretary for Health and Medical Affairs; and, to my right, Dr. Stanley F. Yolles, Director of the National Institute of Mental Health.

I am pleased to come before this committee today to present testimony in behalf of four health bills introduced by the distinguished chairman of this committee. Two of these bills embody extensions of laws which this committee was instrumental in having enacted in past Congresses—laws under which significant contributions are being made to the health of the American people. Each of these bills would carry out specific recommendations made by President Johnson in his health message of January 7, 1965.

H.R. 2986, the Community Health Services Extension Amendments of 1965, would extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community immunization activities, to health services for migratory workers, to general public health services, and to special project grants for community health services.

H.R. 2984, the Health Research Facilities Amendments of 1965, would extend and expand the program of matching grants for construction of health research facilities—a program which has had remarkable success in increasing the health research resources of our Nation.

H.R. 2987, the group practice facilities bill, would authorize loans and loan guarantees to assist voluntary associations in the construction and equipment of facilities for comprehensive group practice, thus encouraging the efficient and economical grouping of scarce medical manpower to the benefit of physicians and patients alike.

I may add, Mr. Chairman, that this is important to the rural sections of this country, which are in great need of physicians, and find it difficult to hold physicians because many physicians will not go into these areas because there just are not the facilities to conduct an adequate practice.

It is our belief, if we could establish a group facility for them, we would be able to retain more of our doctors in these rural and out-of-the-way places.

Dr. Dempsey will be presenting to you more detailed testimony on the group practice bill and the other bills I have mentioned. As a matter of fact, many members of this committee recall that we went into detail last time, and this was part of our overall program which was not adopted by Congress. I should like, Mr. Chairman, to devote my testimony principally to H.R. 2985, the Community Mental Health Centers Act Amendments of 1965.

This bill is directed toward the full implementation of the new national program in mental health which the Congress launched in 1963, and to which the entire Nation is now committed. I know, Mr. Chairman, that you and your committee were instrumental in authorizing many of the tools with which the communities, States, and the Federal Government are beginning to give the new program its shape.

Two years ago we came before you to testify on behalf of legislation quite similar to that now contained in H.R. 2985. At that time, the legislation was part of a total package which included authorization for a construction grant program, and which was but one aspect of the Nation's "bold new approach" to the problems of promoting mental health and preventing mental illness.

Your committee reported favorably on every aspect of the new program save one: the initial staffing grant provisions. In the committee report on the bill in 1963, you supported the idea of Federal assistance in the creation of community mental health services, but you also suggested that such Federal assistance:

* * * should be so tailored as not to result in the Federal Government's assuming the traditional responsibility of the States, localities, and the medical profession for the care and treatment of the mentally ill.

Mr. Chairman, we certainly agree with that basic idea as stated in the report. The Federal Government's support was originally sought because the States, localities, and the medical profession were not able to meet the great demands being made upon them. They now are beginning to find the ways in which they can respond to those demands, and one of the most important ways is through the development of community mental health centers.

Nonetheless, too many States and communities still do not have the one major tool they need. That tool is the support to get these new programs started. In other words, Mr. Chairman, we contend, and we expect to show, that staffing grants are urgently needed to provide the initial stimulus which is necessary if a great many States and communities are to establish and maintain community mental health centers.

In support of our contentions, I should like to summarize the key provisions of the bill and to comment on the development in this field in the last 2 years which so clearly demonstrate the need for, and the potential effects of, the legislation before us.

H.R. 2985 would amend the Community Mental Health Centers Act of 1963, by adding authority to make grants to meet a portion of the cost of professional and technical personnel for the initial operation of new community mental health centers, or of new services in established centers. As the chairman stated in his opening statement, the initial staffing grant for any one center would not exceed 75 percent of eligible costs for the first 15 months, 60 percent for the next year thereafter, 45 percent for the third year, and 30 percent

for the final year. H.R. 2985 specifies that no new grant could be made after June 30, 1970. In other words, it is our contention and our wish that these would phase themselves out.

A staffing grant could be made only if the services to be provided by the center were part of a program providing at least the essential elements of comprehensive mental health services. These essential elements include inpatient and outpatient services, day and night hospitalization service, emergency care, and consultation and education services.

A staffing grant would be made only if the center had received a construction grant under Public Law 88-164, or if a center proposed to provide a new type of service. That covers both situations, those centers now in existence being eligible for a staffing grant if they provided a new type of service.

The Nation is now committed to the urgent and challenging task of providing all our citizens with the most effective mental health services.

Since 1963, with the great support of the chairman of this committee, we have been moving on many fronts in our attack on mental illness. Comprehensive mental health planning has occurred in every State. States and communities have been planning for the construction of community centers. Care and treatment in State mental hospitals have been improved. The Federal Government has intensified its support of manpower training and research.

In fiscal years 1963 and 1964, a total of \$8.4 million in Federal matching funds was appropriated to assist States in the development of comprehensive plans for the provision of mental health services. The final reports of those planning efforts will be ready by the end of this summer. More than 25,000 citizens—and I think this demonstrates the interest in the program—have been actively participating in this planning program, and the planning has been as much local and regional in nature as it has been a State function.

The enthusiasm for the sound establishment of community mental health services has never been higher, and it shows no signs of diminishing. Although the Federal funds which have been supporting this planning program will expire in June 1965, many States have already indicated that they will continue the program entirely on their own resources.

I am certain that initial staffing grants would have the same stimulatory effects as had Federal support for planning. The States and communities are ready to implement the plans. They are eager to build the buildings and provide the services. But too many of them will not be able to take that first big step without the kind of assistance which H.R. 2985 is designed to give.

All the States are heavily committed to carrying the huge financial burden of providing public mental health services in their State hospitals, the annual cost of which, to the States, is \$1.13 billion. Nonetheless, the States also are accepting a commitment to the support of many community mental health services. Twenty-one States now have some form of a community mental health services act. Such acts commonly provide State matching support for community outpatient, consultation, and rehabilitation services. Some of the States and their participating communities are now spending on the order of \$100 million on community mental health services.

To indicate the extent of the support for local services which many communities are now providing, I would cite the fact that there are now more than 1,000 general hospitals which admit psychiatric patients and there are nearly 2,000 mental health clinics. Both of these figures represent rapidly rising trends toward more and more community services.

Despite these trends, the services of these facilities are not routinely available across the country. Such facilities tend to be concentrated in the more economically fortunate States and communities.

Moreover, the community which already has an outpatient clinic probably has a long waiting list, and the patients have a long way to go when they require hospitalization. Nonetheless, these statistics indicate that a great many communities have already made a commitment to the provision of mental health services, and a great many more would like to make such a commitment.

The difficult step to take is the first one. Too many communities will not be able to take this first step without the assistance provided in H.R. 2985.

What may be expected to happen if this aid is not made available and the centers are not established within the next few years? One of the most tragic results of such a situation would be the further entrenchment of existing trends in the usage of State mental hospitals. Those of you have visited some of our State mental hospitals can readily appreciate that up until a few years ago they were rather disgraceful.

About the only care given was custodial care, waiting for the time of the person to expire.

I refer, also, Mr. Chairman, particularly to the rapidly increasing numbers of children and adolescents admitted to State mental hospitals.

If this trend continues, by 1970 the numbers of children and adolescents in State hospitals will be more than double the number in 1960. Trends such as these will obviously be more difficult to reverse in 5 years than they would be now.

Communities are beginning to feel the urgent necessity to start reversing the trends now. If we do not recognize the severity of the mental health situation, as it exists today, and if we do not act accordingly, we will simply be denying to most of our citizens what we know to be the most effective means of safeguarding their mental health.

In this field, when time is lost, the damage is done, and the damage is neither quickly nor easily repaired.

President Johnson underlined this situation in his health message of January 7, 1965:

Few communities have the funds to support adequate programs, particularly during the first years.

Communities with the greatest needs hesitate to build centers without being able to identify the source of operating funds.

Most of the people in need are children, the aged, or patients with low incomes

I think that the President and the Governors of every State and the mayors of every town and city would agree that the Nation cannot afford to wait any longer. The resources are there to be found, but the finding, like the funding, will take time.

Mr. Chairman, this Nation is committed to meeting the challenge of providing modern comprehensive care for its mentally ill citizens.

I urge enactment of H.R. 2985 as an essential step in meeting this challenge.

Now I would like to refer to the additional assistant secretaries. Before Mr. Dempsey testifies on the three bills before this committee, I would like to address myself to section 4 of H.R. 2984 which would authorize additional assistant secretaries for the Department of Health, Education, and Welfare.

I may add, Mr. Chairman, that this request has been before the Congress for at least the past 7 years that I know of. Certainly this committee, your committee, Mr. Chairman, is particularly aware of the rapid growth of the programs of the Department. Much of the legislation giving new responsibilities to the Department was recommended by this committee. But a few facts will illustrate how large the management responsibilities of the Department are today as compared with 1953 when the Department was created.

A total of 125 substantive laws have been enacted since 1953 which either created new programs charged to the Department's administration or expanded existing ones.

Over 70 percent of the more than 100 grant-in-aid and other financial assistance programs currently administered by the Department have been adopted since the Department was established in 1953.

Old age, survivors, and disability insurance trust fund expenditures have increased from \$3.4 billion in fiscal year 1954 to \$17.6 billion in fiscal year 1965. This is an increase of 418 percent.

The Department's budget in 1953 for appropriated funds was \$1.9 billion. The Department's budget for fiscal year 1966, which is now before Congress, calls for total appropriations of \$7.8 billion under existing legislation and \$2 billion under new legislation and for a total of \$9.8 billion. This is an increase of 311 percent.

If the legislation affecting the social security program goes into effect, this Department will then be responsible for trust funds and expenditures in excess of \$30 billion a year.

During the Department's 12-year life, the staff of the Office of the Secretary has not grown sufficiently to keep pace with its responsibilities. I may add at this point, Mr. Chairman, that, in the little over 2½ years I have been here, I think it is really dangerous—really tragic—that I have to keep staff working 12 to 14 hours a day, 6 to 7 days a week, day in and day out. I don't think that that is good management, particularly during the legislative sessions, which are long sessions.

The staff is completely overworked in the top echelon.

The staff in the Office of the Secretary available to assist the Secretary with executive direction and coordination has increased from 88 positions in 1953 to 101 positions currently, or an increase of only 15 percent. This has produced severe stresses and strains. We have requested a modest number of new positions in the 1966 budget for critically needed staff in the Office of the Secretary.

As of now, Mr. Chairman, the Department has 160 going programs to manage.

However, legislation is required to fill the most urgent need in the management of the Department—the lack of sufficient Assistant Secretaries.

Section 4 of H.R. 2984 would accomplish that objective.

Section 4 of H.R. 2984 would do two basic things. First, it would provide two additional statutory positions at the Assistant Secretary level for the Department. Second, it would replace the position of Special Assistant to the Secretary for Health and Medical Affairs, which was established by the reorganization plan creating the Department, with an Assistant Secretary position.

Actually, the Department would only begin to gain two Assistant Secretaries.

There are now only three Assistant Secretaries in the Department: An Assistant Secretary for Legislation, an Assistant Secretary available for general assignments, and an Assistant Secretary for Administration. Except for the conversion of the former position of Administrative Assistant Secretary to Assistant Secretary for Administration, no new positions have been established at this level since the Department was set up in 1953.

As the magnitude of the Department's program responsibilities has mounted, the interrelationships between them have grown correspondingly. The interrelationships are evident in such programs and issues as mental retardation, juvenile delinquency and alcoholism, construction grant programs, problems of the deaf, problems of Federal-State relations, problems of water and air pollution, and numerous other activities that cut horizontally across the assigned responsibilities of various operating agencies of the Department.

Many of these and other subjects require that the Department be represented at a high level in dealing with other departments and agencies.

They also require that a high-level representative of the Secretary be available to deal with State officials, public interest groups, universities, and others. We are spread so thinly that often we have no adequate representation either to coordinate such activities within the Department or to represent the Department at important meetings and conferences. I believe, therefore, that the need for additional Assistant Secretaries is both clear and urgent.

The proposal to abolish the statutory position of Special Assistant to the Secretary for Health and Medical Affairs, and create in its place an Assistant Secretary position, is essentially a proposal to change the title of an existing position. However, it is a very important and needed change. The current Special Assistant to the Secretary for Health and Medical Affairs, and his predecessors have been functioning in much the same manner as Assistant Secretaries.

The incumbent of this position is appointed by the President and confirmed by the Senate, just as are Assistant Secretaries. The scope and importance of the responsibilities of this office are at the same level as those of the Assistant Secretaries.

He acts as the Secretary's principal staff adviser in health and medical policy matters, and assists the Secretary in coordinating the Department's programs in these fields. I do not need to elaborate on the important role of the Department in Federal activity in these areas, since your committee is well aware of it.

The conversion to an Assistant Secretary would clarify the stature of the position for those inside and outside the Department. It would also permit the Secretary to use an Assistant Secretary more effectively, and more flexibly to perform health-related functions and to serve as the science adviser to the Secretary.

On the basis of my own experience, I am convinced that our responsibility for good leadership and for careful stewardship of the authority and funds given the Department calls for additional staff personnel at the Assistant Secretary level to assist in policy determination and coordination.

I might add, Mr. Chairman, as an example, I have stated the Department now has 3 assistant secretaries, and there are 11, plus 2 under secretaries and 2 deputy secretaries, in the Department of State. There are two under secretaries, and one deputy under secretary and six assistant secretaries, in the the Department of the Treasury.

There are one Deputy Secretary of Defense, one director of defense research, and six assistants in the Department of Defense.

The Department of Justice has one deputy attorney general and nine who are equivalent to assistant attorneys general; the Post Office Department has five.

The Department of Interior has five assistant secretaries. The Department of Agriculture has four; the Department of Commerce has four; the Department of Labor has five; and the Department of Health, Education, and Welfare has three.

Mr. Chairman, this concludes my statement. I have asked Dr. Dempsey to present our statement on H.R. 2986, H.R. 2984, and H.R. 2987.

If the committee wishes to question me at this time on this statement, or if you wish Mr. Dempsey to testify, we will proceed according to your wishes. I am available for questioning on House bill 2985 and the additional assistant secretaries, if that is the wish of the committee.

The CHAIRMAN. Mr. Secretary, thank you very much for your statement to the committee. You have expressed to us vividly and exceedingly well your own feelings concerning the proposals under consideration today.

In view of the fact that Dr. Dempsey may not be able to conclude by noon, and in order to relieve you of having to come back, before we get to him I think we might given an opportunity to anyone who may have some inquiry to make on the matters about which you testified.

I am sure, with your arduous duties and heavy responsibilities, you would like to conclude your presentation this morning.

Secretary CELEBREZZE. Yes, Mr. Chairman.

The CHAIRMAN. Mr. Staggers.

Mr. STAGGERS. I have no questions, but I, too, would like to congratulate the Secretary on his able presentation today.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Yes, Mr. Chairman.

Mr. Secretary, I gather from your report that the health centers were not built and that work has not progressed, due to the fact that they lacked staffing; is that true?

Secretary CELEBREZZE. Yes. The planning has been done, but our inquiry of the States has shown that some States are hesitant to proceed with the actual construction unless they can get some relief on the staffing of these centers.

Mr. YOUNGER. Yet, on the first page of your statement, you say that these bills have been passed, and have made significant contri-

butions. If you can't get them built, and they are not in operation, how can they make a significant contribution to the health of the public?

Secretary CELEBREZZE. They have made a significant contribution in that we have overcome the inertia and have at least gotten the States into the planning stage, which we could not get before. It has brought to public attention the need for community mental health centers.

So in that area of planning and coordination, as I said, about 25,000 people have participated. The concept has been sold to the public through the State efforts that we don't need large institutions for mentally ill people, and that through proper planning we can have these community centers and do away with the large institutions.

The CHAIRMAN. If the gentleman will permit an interruption, the language referred to, Mr. Secretary, in your statement, had in mind the extension of the two programs to which you have referred, which have been in existence over a period of time, and which you say have made significant contributions. That has to do with the research bill and the mass vaccination, I suppose.

Secretary CELEBREZZE. Yes. I thought the gentleman was referring to 2985.

The CHAIRMAN. He was, but he went back and referred to the statement you made as to the significant contributions. In your statement you said two of these bills embody extensions of laws, which the committee was instrumental in having enacted by the Congress. These are laws under which significant contributions were made. You were referring to the laws which have been in existence for some time, and which have made significant contributions.

Secretary CELEBREZZE. Particularly the immunization programs.

Mr. YOUNGER. The mental retardation health centers is a law already in existence, Mr. Chairman.

The CHAIRMAN. But only from the last Congress. It has not had time to get off the ground.

Mr. YOUNGER. That is the point I was trying to make. If it has not gotten off the ground, how did it make significant contributions?

The CHAIRMAN. That is what I was trying to clear up for the gentleman. The significant contributions referred to by the Secretary were the two laws concerning which he mentioned, "two of these bills which have already been part of the program over the several years." He did not say the mental health centers. Let's get the record straight on it.

Mr. YOUNGER. The mental health centers is one of the bills.

The CHAIRMAN. Not one of the two referred to, if the gentleman will reread the statement. I want the record straight on this.

Have you anything further?

Mr. YOUNGER. No.

The CHAIRMAN. Mr. Rogers?

Mr. ROGERS of Texas. Mr. Secretary, there have been some rumors that concern the veterans hospitals being closed. Has the Department of Health, Education, and Welfare worked up a plan to utilize these facilities in connection with this or any other health program?

Secretary CELEBREZZE. I think it is more than a rumor that the veterans hospitals will be closed. The Veterans' Administration was planning on closing them. There has been declared a moratorium

on them, I think, by Congress. But they are closing these institutions because they are outmoded. Your question is, Do we plan to use these facilities?

Mr. ROGERS of Texas. Yes.

Secretary CELEBREZZE. Not that I know of at this time.

Mr. ROGERS of Texas. Do I understand you to say that they are being closed because they are outmoded?

Secretary CELEBREZZE. They are being closed for two reasons. One is because you can give more adequate treatment in the newer facilities with the better staff and the other is for economical reasons.

But economical reasons alone are not controlling reasons, as I understand it. I am in an area which I should not be in right now. I think you better address that question to the Veterans' Administration.

Mr. ROGERS of Texas. I was hoping that there had been some coordination of activity between the Veterans' Administration and your department.

Secretary CELEBREZZE. There has been coordination to this extent, that the Public Health hospitals which are outmoded, which we announced we will close out, those services will be rendered partially by the Veterans' Administration and partially by the local community hospitals.

In that area, there has been complete coordination between the Veterans' Administration and the Public Health Service.

Mr. ROGERS of Texas. Mr. Secretary, don't you have a great deal more need for public health facilities than would be provided by any existing laws or by the bills presently pending before this committee?

Secretary CELEBREZZE. Are we referring now to mental health?

Mr. ROGERS of Texas. To all of the public facilities. In other words, these bills that we are talking about with regard to mental health are not going to solve the entire problem that you are faced with, are they? You are going to need further legislation in the future in the expanded operations, if we meet the requirements.

Secretary CELEBREZZE. Mr. Rogers, are you addressing yourself to mental health facilities or hospitals generally?

Mr. ROGERS of Texas. At the present time, in the last question, to the mental health facilities.

Secretary CELEBREZZE. Our basic problem in the mental health field is to get small community centers where we can give adequate treatment in the home community. That is paralleled, I think, with the comprehensive medical centers, for which there is another bill pending. What is happening today is that, first of all, as we build up the necessary forces of trained personnel to staff these, what we are trying to do is concentrate and get the greatest utilization out of the skilled staffs we have now.

The concept of one big institution, addressing myself solely to the mental health field, has been outmoded. We find that better treatment can be given on a community level because there is a difference atmospherically—they are in their home community and can be home for the weekends, or the parents, the husband or wives can visit them—and they get away from the complete institutional care.

In that area a great deal has to be done yet.

Mr. ROGERS of Texas. But you do not plan to use any of the veterans facilities that are being closed?

Secretary CELEBREZZE. No.

Mr. ROGERS of Texas. Your next reference had to do with training the staff.

Secretary CELEBREZZE. First of all, so that we can keep the record straight, the Federal Government is not going to build hospitals. This is a State function. We are going to help the States. When you say to me do I intend to use the closed veterans hospitals for mental health, we are not going into that area at all.

That is a State function. If the State, in its wisdom, sees a facility which they think they could remodel and convert, we would help them on that basis.

Mr. ROGERS of Texas. You would not be prohibited under this legislation from permitting them to do that?

Secretary CELEBREZZE. No, under this legislation you can get a grant for two reasons: One, that you establish and, two, that you increase or put in a new service. If they went into that area referred to, and it is a new service, they would be eligible for a grant under this bill.

Mr. ROGERS of Texas. And you would have no reason not to help them out?

Secretary CELEBREZZE. No.

Mr. ROGERS of Texas. Now, Mr. Celebrezze, with regard to trained staff personnel, I presume you are having great difficulty in providing doctors in these areas; are you not?

Secretary CELEBREZZE. Yes, we are, but we are making good progress because of the interests of this committee and the passage of the many pieces of legislation which help us in our training program.

Mr. ROGERS of Texas. My inquiry about that goes to this: What is the ratio of doctors to the general population throughout the United States?

Secretary CELEBREZZE. 149 to 100,000. That is 149 doctors for every 100,000 population.

Mr. ROGERS of Texas. Do you think that is a sufficient number of doctors?

Secretary CELEBREZZE. No. That is why we passed the Health Professions Act last year, in order to produce more physicians, dentists, and other professionals.

Mr. ROGERS of Texas. Do you think that is going to develop where it will produce those additional?

Secretary CELEBREZZE. Yes, indeed.

Mr. ROGERS of Texas. Do you think, Mr. Secretary, that will tend to help staff the areas, the sparsely settled areas, that are now going without doctors?

Secretary CELEBREZZE. Yes, but I think you ought to wait until Dr. Dempsey testifies on the community health facilities, which has directed itself particularly to that point of keeping doctors in the smaller communities.

Mr. ROGERS of Texas. Thank you very much.

Secretary CELEBREZZE. It is the Group Practice Act that I should have referred to.

The CHAIRMAN. Mr. Devine.

Mr. DEVINE. I have no questions, Mr. Chairman. I would just like to welcome the Secretary here this morning.

Secretary CELEBREZZE. Thank you, sir.

The CHAIRMAN. Mr. Macdonald.

Mr. MACDONALD. I have one or two questions, Mr. Chairman.

In response to a question placed to you by Congressman Rogers, you indicated that the VA was going to take over some of the patients that had formerly been treated by Public Health hospitals. Is that correct?

Secretary CELEBREZZE. Yes, sir. In arranging for the closing of some of the outmoded hospitals—and remember, some of them were built in 1870—we have a working arrangement that we can utilize empty beds in the VA hospitals where they are available, and also in the community hospitals. We have worked those arrangements out.

Mr. MACDONALD. The reason I asked the question, not to be argumentative about it, is I was thinking particularly of Massachusetts, my home State, and the fact that you closed down a hospital in Boston which is not outmoded and which is presently very well staffed. It services the entire fishing fleet from New England.

It takes care of the merchant seamen and the maritime people. There is a great need for it. I was very interested when you further told us—followed up your statement by saying that these community hospitals should be kept because the patients families could visit them.

I was wondering where the people who had been treated in the Boston hospital under the Public Health Service are now going to be treated and how they are going to be visited by their families.

Secretary CELEBREZZE. You must remember in closing the facilities we provide outpatient services. There will also be outpatient services in the Boston area. Secondly, we entered into agreements with your private hospitals in the Boston area and also the veterans hospitals in that area.

Mr. MACDONALD. But they are already overcrowded. I could also point out that the VA and Public Health Service coordinated efforts to close hospitals in Massachusetts, practically simultaneously, the closing down of the only facility in western Massachusetts by the VA and the only service in New England of the Public Health Service.

Secretary CELEBREZZE. That was the concept of it. I am sure that the Surgeon General, who is here and has worked on it, can give you a more detailed explanation.

Mr. MACDONALD. The only reason I brought this up is because I wrote your office some time ago and I have been waiting for a response over a month.

Secretary CELEBREZZE. Sometimes these questions are highly technical and we want to get all the information before we answer.

Mr. MACDONALD. I suppose the other side of the coin is that sometimes there is never a really good reason, and, therefore, it takes some time to develop one.

Thank you, sir.

The CHAIRMAN. Mr. Keith.

Mr. KEITH. Thank you, Mr. Chairman.

I am very much interested in this program. I have in my district Mr. Secretary, the South Shore Mental Health Association, which I think is the kind of regional facility you hope communities will adopt.

If there is no objection on the part of the chairman, I would hope that this report could be made part of the record as an example as to what other communities might do if they fully utilize the program which you envision.

There being no objection, I assume that that will be done.

The CHAIRMAN. Without objection, it is so ordered.

(The information referred to is as follows:)

SOUTH SHORE MENTAL HEALTH CENTER, SOUTH SHORE MENTAL HEALTH
ASSOCIATION, 1964

This is an attempt to describe briefly the mental health program in the South Shore area. The chief mental health facility is the mental health center located in Quincy, which provides most of the psychiatric facilities locally. The Mental Health Association is its community partner, and they work together with all the resources available; the most important of these being the Medfield and Foxborough State Hospitals, the South Shore Association for Retarded Children, the Quincy City Hospital, the East Norfolk Court, and other service agencies.

Services are provided to Quincy and eight other towns, including Braintree, Cohasset, Hingham, Hull, Milton, Randolph, Scituate, and Weymouth. The population is 251,417 in an area covering about 125 square miles. Except for 561 Negroes, and 257 others, the people are white, with only 25 percent being either foreign born or of foreign stock; 96,664 of those over 21 (151,352) are in the civilian labor force. The median income is \$8,511; the unemployment rate is about 2½ percent, with a little over 1 percent on welfare. Three percent have an income of less than \$3,000. The crime rate is a little over 2 percent.

The median number of years of completed education is 12.3. There are 52,588 enrolled in the public schools, with an average of 24.3 pupils per teacher. The average cost per pupil is \$382.

Of the nine towns included in this area, all but Scituate, Hingham, and Hull are in Norfolk County. The three named are in Plymouth County, and these three are also served by the Foxborough State Hospital, the others by Medfield. There are about 300 patients a year going from the six towns to Medfield, and about 35 a year to Foxborough. Both hospitals are in Norfolk County, and about the same distance from the towns they serve. It might be a consideration to have them all served by the same hospital, probably Medfield, because of the many programs we have developed with them.

There are three general hospitals, of which the South Shore in Weymouth and the Milton Hospital in Milton are private, and the Quincy City Hospital (public) which serves that city. Neither of the private hospitals has a psychiatric unit. The Quincy Hospital accepts psychiatric cases for diagnosis and treatment, and also has a neuropsychiatric clinic. The other hospital in the area is the Norfolk County Tuberculosis Hospital in Braintree, which treats acute and chronic tuberculosis cases. They have one psychiatric consultant.

PSYCHIATRIC FACILITIES

1. Medfield State Hospital: About 300 patients per year from 6 of our towns.
2. Foxboro State Hospital: About 35 patients per year from 3 of our towns.
3. Quincy City Hospital: All cases seen on emergency. No specified number of psychiatric beds. Five psychiatrists on rotating service. Patients not admitted for treatment are referred to private hospitals or Medfield. The neuropsychiatric clinic employs two full-time social workers. One doctor sees patients Friday mornings from 8:30 to 11, and is also available for emergencies. Total number seen in 1963 was 77. This clinic is for Quincy residents only. The State department of public health sponsors a clinic for alcoholics two nights a week at the hospital. Anyone from the South Shore area is eligible for treatment by appointment. The average attendance at the clinic is 10 to 15. Only one psychiatrist carries on this program, without any assistance except for someone to make appointments.
4. South Shore Mental Health Center: (a) Diagnosis and treatment, 447 children and 229 adults in 1962.
 - (b) Consultation in all public schools on weekly basis offered to nurses, clergy, physicians, social agencies.
 - (c) Research under a full-time director, several different projects sponsored by the National Institute of Mental Health, and foundations.
 - (d) Education: With the mental health association carries on a very active speaking program.
 - (e) Training psychiatric social workers; master's candidates in maternal-child health nursing; master's candidates in psychiatric nursing; doctoral candidates in counseling psychology; doctoral candidates in clinical psychology; advanced candidates in school psychology; first-year graduate students in clinical psychology; psychiatric residents in child psychiatry.
 - (f) Special programs. Aftercare for discharged psychiatric patients from State hospitals; Court Clinic consultant services, including diagnostic evaluations; mental health information and in-service training for local and State police.

(g) Mental retardation. Three preschool nurseries; occupational program for retardates over 16; sheltered workshop (to begin this month).

(h) Rehabilitation counseling provided for retardates and discharged mental patients.

(i) Screening agent for cerebral palsy clinic.

(j) Diagnostic evaluation for children under 750 law from all public schools in the area.

OTHER MENTAL HEALTH FACILITIES

Halfway house under joint sponsorship of Medfield State Hospital, Mental Health Association, and center.

Family service agencies

Catholic family counseling, Quincy, serves whole area. Two consulting psychiatrists; five social workers full time, two part time. Age 12 up. Fees \$2 to \$15, 55 percent free. Nineteen hundred and sixty-two—1,000.

Family Service Association Greater Boston, Quincy, serves all but Quincy. Two consulting psychiatrists, four social workers. Age 12 up. Fees to \$15, 60 percent free. Nineteen hundred and sixty-two—310.

Quincy Family Service serves Quincy, occasionally others. Mental Health Center consultant: two social workers. Age 14 up. Fees \$1.50 to \$12. Sixty percent free. Nineteen hundred and sixty-two—623. Also successfully trains and operates homemaker service.

Protestant Social Service serves whole area. Mental Health Center consultant; two social workers. Age 12 up. No fee, except for placement. Nineteen hundred and sixty-three—144.

Adams Counseling Service, Quincy, private for South Shore, one consultant psychiatrist; four social workers. Fees \$12 individual, \$6 group therapy; by appointment.

District Court of East Norfolk, Quincy (for adults). Limited treatment through division of legal medicine. One psychiatrist, two social workers.

MSPCC, Quincy, serves South Shore. Three social workers; one psychiatric consultant. Children to 16. No fees. Nineteen hundred and sixty-two—800.

OTHER SERVICES FOR RETARDATES

South Shore Association for Retarded Children actively sponsors services provided by the Mental Health Center. Raises funds to provide space and some equipment for nursery schools, occupational center, and sheltered workshop.

Private

St. Coletta's Day School, 85 Washington Street, Braintree. Ages 7 to 11, both educable and trainable, boys and girls, with IQ of 50 or above. Charge \$25 per month, plus \$25 per year for milk. All religions; serves South Shore.

Smith School, 68 Smith Road, Milton. Resident for 35 educable and high trainable boys. Private school fees.

Camp Harmony Hill, 39 Beechwood Street, Cohasset. Nine weeks in summer. Educable and trainable; epileptic and cerebral palsy. Age 2 to 16. Forty-five dollars per week. Owned by Massachusetts Special Class Teachers, Inc., and operated by them. Five counselors. Takes care of 40 children weekly, 350 during season.

SUMMER DAY CAMPS

Braintree, Hingham, Hull, Milton, Quincy, and Weymouth all have day camps in the summer for retarded children. They are sponsored by the South Shore Association for Retarded Children, and Quincy Recreation Department has had one for 80 children, using volunteer young people to work with them. It has been very successful.

All of the towns have special classes either for educable or trainable retarded children in the public schools.

The present South Shore Mental Health Center has developed its broad program in the last 10 years, although it was started in 1926 as the Quincy Habit Clinic. It was one of the first opened by the division of mental hygiene and was sponsored locally by the Quincy child welfare program. The habit clinic was conducted on a 2-day-a-week basis until 1954, when it opened for 4 days a week. In 1955, at the urgent request of adjacent communities, services were expanded to include the seven other towns, and it was in 1963 the town of Randolph was admitted as a part of the South Shore area.

The Mental Health Association was formed in 1944 as a community partner to provide support for the clinic. In 1955, when the whole mental health movement was gaining tremendous impetus across the country, the South Shore began to expand its services. The success of the various projects on which it has embarked has been due to the high caliber and enthusiasm of the clinic staff, and the active participation of the mental health association made possible when an executive director was employed by the latter in 1957. One board of directors has served the professional and the lay organization, and have thus worked closely together. It has always been a policy of the program to be informed on local needs, develop the existing resources, and plan with other community agencies for the unmet needs. Since 1959 we have had a close alliance with Medfield State Hospital, which takes care of about 300 patients a year from this area. The hospital has been active in planning with us, and other social agencies in Quincy, an aftercare program which now serves 200 discharged mental patients. The aftercare clinic provides followup for all, except that it does not assume responsibility for alcoholics or court cases. The East Norfolk district court, through the division of legal medicine, provides for the latter, and we hope that someday we can come up with some kind of a successful program for alcoholics.

For some time the clinic has provided diagnostic evaluation for the cerebral palsy clinic, and also for the nursery school for the South Shore Association for Retarded Children. With the allocation of funds provided by the legislature last spring, the clinic has now expanded its services to enlarge the occupational center, add two more nursery school classes, and set up a program for a sheltered workshop which is scheduled to open this fall. The staff has been enlarged to take care of the retardate program and includes a rehabilitation counselor and occupational therapist, as well as the regular teams for the emotionally disturbed.

The consultation program for the public school systems and other agencies now consumes 40 percent of the staff time working outside of the clinic in the communities. This is considered a step in the direction of preventive mental health which picks up many problems before they might progress to the point of hospitalization.

Juvenile offenders in this area are discussed at weekly meetings before they are adjudicated. These meetings involve key people in the area and include Catholic and Protestant chaplains, the division of child guardianship, the MSPCC, the Protestant Social Service Bureau, the schools, the police (probation officers) and a staff member of the clinic. The purpose is to provide the court with information regarding the youngsters to enhance a meaningful and just disposition of each case. All cases of juvenile offenders in this area are reviewed in this manner. Some are referred to the clinic for diagnostics and/or treatment.

In 1960 the mental health association did a spot survey of the needs and resources of the towns named above. The survey was done by oriented volunteers calling on professional people including doctors, lawyers, clergymen, school personnel, social agencies, and police. The purpose of the survey was to ascertain the mental health needs of each of the communities in order to determine the most effective use of funds and resources for the future development of the mental health program on the South Shore. The results of the survey showed that the participants agreed that the problems were concerned with alcoholism, marital relations, adolescents, and juvenile delinquency. The greatest needs were expressed for an adult clinic, more resources to meet the needs of adolescents and more family and marriage counseling services. The doctors reported that up to 75 percent of their patients were suffering from psychological rather than physical ailments. Clergymen were found to be the first source that people used who considered themselves in trouble.

The survey probably indicated that problems in the South Shore area are no different than anywhere else, especially regarding alcoholics. There are three or four AA units on the South Shore, one Al-anon group for the wives of alcoholics, and indications that Al-a-teen may have a place soon. The alcoholics clinic at the Quincy City Hospital is operated by an experienced psychiatrist who is greatly handicapped by a lack of any kind of staff. This is due to the fact that money for the clinic is given through the Quincy City Hospital, and the hospital will not agree to hiring a social worker on a realistic salary scale, which would be above the one offered their own social workers. We have had many meetings with people from the division of alcoholism involving both the professionals in the communities and different groups of young people. The general feeling of the former is that information regarding the effects of alcohol should be transmitted to schoolchildren before they start to drink, which is unfortunately at a very early age. Also some way should be worked out to reach parents who tend

to be irresponsible about the whole matter. How to do this is the great unanswered question.

The problems of adolescence and juvenile delinquency are reflected in the report of a local police chief who stated that, "I feel that the most serious mental health problems result from an apparent breakdown in family life and family discipline" as well as "the degrading entertainment adults and children are exposed to. Finally, from the fast pace of modern living whereby father and mother have to work just to keep up with the Jones'." This same chief tells of police who are thwarted in their attempts to maintain law and order by parents who either don't care or get their children "free from the due process of law."

Many of the professional people expressed the opinions that people in general do not have a responsible attitude toward their children. It is much too easy to say "yes" rather than lay down the law and stick with it. Maybe this is our present culture, but if mental healthers are not concerned, then no one will be.

The greatest need in the South Shore mental health program at this moment is more space. Legislation was introduced and passed last year to provide a new mental health center in Quincy. Subsequently, the sum of \$75,000 was allocated and approved in the capital outlay budget for an architectural study for the building. In the regular course of progress, we anticipate that a sum of money sufficient to put up the building will be allocated in next year's capital outlay budget. The land has been provided, without charge, by the transference of 2½ acres of land from MDC to the department of mental health.

Our present program will be moved to this building. This includes clinics for adults and children, the training program, research, the entire program for retardates which includes a nursery school, occupational center, and sheltered workshop. We would also hope to have beds for short-term treatment, day care services for retarded, night care for both emotionally disturbed children and adults. We would also need rooms for conferences, a library, and a gymnasium.

Facilities not already being planned for the new mental health center and urgently needed include residential treatment for 25 to 40 new children a year, ages 7 to 17. This could probably be best provided by regional planning for areas around us, and perhaps provide a 100-bed unit to start with. At the present time 5 of the towns have special classes for "750" children and the others hope to provide special classes in 2 years. Those already in existence are in Braintree, Hingham, Hull, Randolph and Quincy. Most of the towns have classes for retardates with the exception of Cohasset and Scituate.

We have been working toward this new building since 1959 and meantime the mental health program has expanded to its physical limits in the space provided. We have other new programs in the planning process for which room must be provided. Over the years we have built up services in answer to the needs of the area as they were presented. We have the wholehearted backing of the community and a lot of unexplored possibilities to develop.

The South Shore Mental Health Association has been effective in its legislative program for needed funds and facilities. It has been an active liaison between the clinic and the communities, working out with school systems and other agencies problems of mutual concern.

Historically, physicians in the community have played a vital and active part as board members in program planning. The association has always made it a practice to have them constitute one-third of the number of directors, and they have been of inestimable help to us.

We think down here, that the program has been the result of the joint efforts of the association and the clinic working together, one representing the professional services, and the other the necessary support of the lay people.

(Submitted by Roberta B. Manton, executive director, South Shore Mental Health Association, October 21, 1964. Information regarding services of other agencies was obtained by the forms sent out by the planning committee and surveys done locally.)

FIELD TRAINING IN COMMUNITY MENTAL HEALTH

Presented by Saul Cooper, M.A., assistant director, South Shore Mental Health Center, at Annual Convention of American Psychological Association September 4, 1964, Los Angeles, Calif.

The remarks which follow are based on a 10-year program of development in community mental health at the South Shore Mental Health Center. This program had its earliest roots in a "habit clinic" established in 1926 on a 1-day-a-week basis.

We feel the need to first comment on the concept of community mental health as it is perceived and used by various mental health facilities. It is interesting to note the proliferation of titles and descriptions in the literature which purport to be in the field of community mental health. Our impression is that for the most part these programs and articles reflect (1) specialized clinical programs which have now broadened their clinical base; (2) clinical programs which have combined inpatient and outpatient facilities; (3) clinical programs which make brief excursions into the community at the behest of their clinical case needs; (4) comprehensive programs which have begun to develop a systematic and theoretical public-mental health approach to the unique mental health issues and problems reflected in the communities they serve.

While this fourth group of programs are still quite rare, they represent for us the appropriate perspective for agencies in community health activities and it is this type of field training facility that will be described.

The South Shore Mental Health Center serves nine cities and towns with a combined population of 250,000 people in a middle class area about 11 miles south of Boston, Mass. The Center has been approved by the American Association of Psychiatric Clinics for Children and the American Medical Association for training in child psychiatry and by the American Psychological Association for training in clinical psychology. In addition, we serve as a training unit for (1) second-year field placements in social work; (2) internships in counseling and school psychology; (3) field placements in psychiatric and maternal and child health nursing for masters candidates in nursing; (4) rotating weekly orientation placements for undergraduates from a hospital school of nursing; (5) a newly developed program which, in conjunction with the Massachusetts Mental Health Center, offers a 12-week field placement for rehabilitation counselors.

Field training opportunities in community mental health at our Center seem to fall into 10 reasonably distinct programs; and it is interesting to note that in 1963, 41 percent of total staff time was devoted to these community programs. Each of these programs will be briefly described as it represents a field training opportunity for psychologists in community mental health.

THE SCHOOLS

Case consultation, administrative consultation, and inservice training are routinely offered and used by each of the nine school systems in our area. In addition to weekly didactic seminars at the clinic for staff and students, each student is given an opportunity to accompany a consultant for a half day each week to a particular school system. Since this program has been in existence for a number of years the local schools quite readily accept the notion of a trainee accompanying the staff person as a nonparticipant observer. In some instances, as the academic year progresses, the student is given an opportunity to actively participate in the consultation or inservice education program as his skills and knowledge increase. In this particular setting the student has an opportunity to learn about the nature and functioning of schools as social systems as well as to become familiar with techniques and procedures for carrying out mental health consultation in this type of setting.

SOCIAL AGENCIES

Field training opportunities in this area are focused on family service agencies and welfare departments of the various cities and towns. With the former group case consultation is the primary service requested while with the latter group both inservice education and consultation are requested. In addition, other social agencies such as the YMCA and the various scout organizations involve the mental health center staff with their intraining programs for lay and professional leaders. Youngsters who have difficulties adjusting to a Y summer camp program or a Boy Scout troop may serve as the focus for a consultation request.

JUVENILE COURT

In this setting, psychologists, from the clinic staff helped to develop and participate in a precourt conference where a number of community representatives such as the school attendance officer, social agency representatives, police department representatives, welfare department, and others confer weekly immediately prior to court in an attempt to pool whatever information exists in the community about the particular child who will be brought before the judge. This group then makes a tentative recommendation for the judge's consideration as he hears

the case. The juvenile court consultant also serves as a liaison with the probation department so that findings from clinical studies done on court cases can be properly interpreted for disposition to the court.

POLICE PROGRAMS

Law enforcement personnel and mental health personnel have, for some time, been rather reluctant partners in the handling of psychiatric patients. By collaborating with police departments at both State and local level, it was possible to develop specific inservice educational content for the training of police personnel in the field of mental health. The use of films and lectures as well as discussion groups helped to establish some early channels of communication through which police and mental health personnel could begin to work out some of the difficulties involved in an effective partnership. In addition to this broad-based inservice education program, case consultation is available to the various police departments at a local level who may call upon a Center staff member when faced with a situation with mental health implications.

CLERGYMEN

With increasing data available in the field suggesting that people take their troubles to many other sources in lieu of a mental health center, it became rather clear that clergymen played a critical role in any program with a preventive emphasis. A program was developed, now in its fourth year, where a group of ministers met on a biweekly basis with personnel from the Mental Health Center to discuss issues and problems common to both groups. This program went through some rather distinct and interesting phases where initially the Mental Health Center staff were presenting rather formal and didactic material on such topics as grief, school phobia, and delinquency. After a few months, the ministers' group requested case material on these and other topics and a few months later, during the third phase, the ministers themselves began to bring in case material for discussion. The final phase which occurred after 2 years of such meetings had the ministers bringing cases for consultation both to the group and to individual clinic staff members by phone or by visits. It would appear that appropriately structured programs offered to ministers in our area supplied a service which helped the ministerial group to function somewhat more effectively in their own role while at the same time validating for the Mental Health Center personnel the very large number of cases that would ordinarily be classified as psychiatric cases which were being carried by clergymen.

NURSING

This program offers mental health consultation to visiting nurses, to public health nurses, to State hospital nurses and to staff nurses and supervisors in general hospital settings. In addition a number of inservice training programs have been given for different nursing staffs. It has been our experience that the entire nursing program offers an excellent opportunity for field training for all of the mental health disciplines. The traditional freedom of community movement and access afforded to nurses has been a major strength in the development of such activities.

RETARDATION SERVICES

The average student in any of the disciplines rarely has an opportunity to work closely with the full range of mental retardates. With the establishment of a comprehensive retardation service including two nurseries, an occupational center, and a sheltered workshop, all staff and students have an opportunity to deal with retardates ranging in age from approximately 3 to 40; in addition, the existence of these three distinct facilities offers excellent opportunities for consultation to teachers, occupational therapists, and rehabilitation counselors who are responsible for the day-to-day effectiveness of the activities.

CEREBRAL PALSY

The Mental Health Center serves as a screening agent for a Cerebral Palsy Clinic. In this role, diagnostic evaluations and some limited treatment are offered. Consultation to the Cerebral Palsy Nursery offers an opportunity to participate in a collaborative program where specialists in physical medicine, rehabilitation, orthopedics, and speech therapy can pool their data with the mental health specialist to arrive at an appropriate community disposition which is in harmony with

the total needs of the patient. This, in contrast to programs where independent specialty recommendations are frequently in conflict with each other and thus forces the family into painful decisionmaking which may not be appropriate and which, in most instances, could be avoided. Field training opportunities in a program for physical handicapped provides the psychologist with an additional experience not ordinarily available.

RESEARCH

Research is an integral part of the center's activities. Recently research programs have included a study to find alternatives to hospitalization of severely disturbed children; a 6-year investigation of juvenile delinquency; and techniques for assessing the degree of emotional disturbance of children in the classroom. A present, the center in collaboration with a State hospital and other community agencies, is conducting a federally sponsored project designed to demonstrate the effectiveness of a community oriented after-care program for discharged State hospital patients. Bridge positions and joint training opportunities represent unique extensions of this program. The following projects are now evolving: Assessment of exceptional children, underachievement, evaluation of mental health programs, paternal loss, and the teaching of behavioral sciences in the elementary grades.

Research requirements in community mental health presently represent some of the most difficult challenges in design and methodology for the psychologist; and yet effective service programs in these new types of activities must feel obligated to structure themselves in such a way that field opportunities for research exist and are exploited.

Meaningful research in community mental health programs should carry the highest priority.

MENTAL HEALTH EDUCATION

This service is provided by the professional staff who are members of the speaker's bureau of the mental health association. Mental health education is an integral part of the clinic's services provided through the use of discussion groups, films, and speakers. Speakers are available for parent-teachers' associations, service clubs, church groups, and other interested organizations. Mental health education is important in encouraging the early recognition of potentially serious emotional disturbances in the community in order to facilitate prevention and care. Such programs also heighten community sensitivity to mental health needs and can serve as an impetus for necessary legislation and community action.

From the point of view of field training, developing skills in mental health education affords the psychologist a unique opportunity to get close to the community and thus be in a better position to discriminate perceived community needs from felt community needs which, in many instances, are in reality a reflection of the professional's social system projected onto the community.

In closing, a few general comments and observations. Community mental health practice involves specific identifiable functions and procedures which are sufficiently unique to require specialized field training in addition to the body of content which might be offered in the academic setting.

In our experience, field training in community mental health seems to occur at three levels. The first level which we consider the general orientation, usually represents a brief time span of up to 3 months at the center. This level offers an exposure and a general understanding of some of the issues and procedures in community mental health and can be offered to a wide variety of professionals and semiprofessionals in many disciplines. It clearly does not suppose the development of specific skills.

The second level can be termed a basic training level and usually lasts from 6 to 12 months. In this situation, it is assumed that the professional involved has already received a fairly intensive training experience in his own particular discipline and that, with adequate and continuing supervision, he might be able to function in a community mental health program at a junior staff level.

The third level might be called that of the independent practitioner. This level, in our experience, seems to require a field training investment of approximately 18 to 24 months. Here again, the trainee should have completed the requirements of his own professional group and upon completion of his field experience in community mental health should be ready to operate independently in any appropriate setting.

It must be noted that these time limits are somewhat arbitrary, depending upon the caliber and personality of the student involved; but in general they seem to apply fairly well independent of the discipline.

It is felt that, with the beginning development of a body of theory and practice in community mental health, specific field training opportunities become a necessary adjunct to the academic program in order to supply the broad range of experience and opportunities necessary for effective practice.

Finally, a strong clinical base including both adult and child services supplies the best springboard for a meaningful community mental health program.

Mr. KEITH. I would like to point out that Massachusetts has done a relatively good job when compared to other States. I don't think Massachusetts should fall under the blanket citation that you made in reference to the unusual State treatment of this very serious problem. In the year 1962, the South Shore Mental Health Association had a budget in the vicinity of \$260,000, and \$172,000 of that came from the State.

That is an indication that Massachusetts is recognizing this problem. This is in just one regional community center serving nine separate communities.

Secretary CELEBREZZE. The State of Massachusetts is planning on going into 10 centers. They have indicated that to us, that their desire is to build 10 centers.

Mr. KEITH. It seems to me that with the formula you outlined, unless they inaugurated a new program, they might not be eligible for very much assistance.

Secretary CELEBREZZE. Not a new program, but increased services. That is a rather flexible provision. In other words, what we are trying to do is to provide better care than they are doing now, in order to take advantage of all the new and modern techniques that are available for the treatment of the mentally ill.

Mr. KEITH. I would infer from the report that I have in my hand that these people are most alert in their thinking and they have a very comprehensive program. I would hope that this organization, which has recognized its responsibility in a State which has, to a large extent, also recognized its responsibilities, will, nevertheless, be able to participate in a way where their past initiative will not penalize them.

Secretary CELEBREZZE. I think your State coordinating plan, your comprehensive plan, which is run by the State—we don't run these programs, but the States do—will take care of that. In addition to what Massachusetts is doing, they have expressed a desire to make use of Public Law 88-164. Over and above what they are now doing they want to establish 10 more community mental health centers.

I am sure that our attitude is not going to be that if there is an existing establishment which can render good service which can, with a little help from the Federal Government, increase their services—we are certainly not going to slam the door on them.

Mr. KEITH. What I am getting at, and I think you touched on it in your last statement very pointedly, is this: We will assume that Massachusetts is doing a good job, but they still need nine more centers of this sort. Are you going to reach in and tell them where they should spend this money?

That they cannot spend it, for example, in one currently existing facility because they have nine other areas that do not have any facilities? Are—or are you just going to give Massachusetts an allotment and let them spend it in their own manner?

Secretary CELEBREZZE. I will refer that question to Dr. Yolles, who has been working with this program. With your permission, I will have him answer it.

Dr. YOLLES. In running this new program in the case of Massachusetts, for example, we would look at the State plan for staffing which would be submitted. The State will make a determination of the areas of need and will assign priorities to those institutions that most need the staffing as well as the construction.

We would take these priorities into consideration. This program, of course, would be on a project grant basis rather than a formula grant basis simply because it allows for more flexibility at the present time. Those facilities and those States and communities that are most ready to receive aid and are willing to extend their services and provide new services can receive assistance immediately.

I would emphasize that those areas of greatest need can be helped immediately. In the case of Massachusetts, and the 10 centers proposed, the State proposes to build centers which would meet all the requirements of the Federal Government.

Mr. KEITH. I understand the answer, but I am afraid it poses some problems in that to a degree it could be said to penalize those communities and those States which have assumed their responsibility.

Secretary CELEBREZZE. I think the word "penalize" is wrong there. What we are trying to do here—

Mr. KEITH. If I may interrupt, Mr. Secretary, let's assume that one State has done a good job and has the kind of facility that you propose for all States, in being. Let's say that Massachusetts or Rhode Island, or Hawaii, have done a good job. Somebody in that State has sold it to the people and they have, therefore, good mental health facilities in communities in accordance with the prescription that you would dictate.

Would they be eligible for, as we would say in Massachusetts, equitable treatment in the disposition of Federal funds?

Secretary CELEBREZZE. First of all, let me say this to keep the record straight. In all of our programs we work through a State organization. The State organization makes a great deal of the determinations in these areas. It is true that what we are trying to do with this legislation is uplift that which we already have.

We don't want the status quo. You say that in certain areas where they are doing a good job, are they to be penalized? My answer is that they will not be penalized. On the other hand, you always have that question to consider in any program that the Federal Government enters into. I recall when we passed the Federal Highway Act in Ohio—and I am sure members of the committee recall this—that we had built our roads and we said, "You have penalized us. We have already built our roads. Give us credit for the roads."

That question is always involved. What we are trying to do is to get more than the State is doing now. In other words, it is a stimulus. The Federal Government says: "We will assist in supporting some of your staff. We will give you grants to help you put up buildings. We will for 4 or 5 years pay some of your staffing costs."

That is a stimulus to do something more than they are doing now. If all we are going to do is have the Federal Government come in and take over what the State is doing, and merely exchange State dollars for Federal dollars, then we are not accomplishing our purpose.

Mr. KEITH. I don't want to pursue this too much further, but I don't think any of us at this table would have too much argument if there was a formula comparable to what they did in the highway program, assuring each State of at least some substantial share.

I agree with your basic premise that we must lift up the communities where the need really exists. But I do think if you took two States, narrowed it to that, with one having done a poor job and the other having done a good job, and each of these States contributed relatively equally to the pot, it would, reduced to that simple term, be unfair treatment of that State which had done a good job.

I do hope this committee can work out a way where these tax dollars, which are collected nationwide, can go into areas where they are doing a good job as well as into those areas where they have not done a good job.

I am sure that the committee can.

I have one other question on another subject. We don't have the pleasure of your company as often as we would like to have it up here. But I have not seen very much in the press or in agency statements concerning the impact on veterans hospitals should the King-Anderson bill be passed, and I would like to have you comment on that.

Secretary CELEBREZZE. I would rather withhold my comments because the committee is now in executive session on that and we are working with them. They are marking up the bill now and we are working in all these areas.

Mr. KEITH. So, too, is the whole House. They are very much concerned about this. I really personally feel I would like to have your comment if you can give it. I feel that if every veteran becomes a part of this social security system, as he would eventually, that he would then be able to choose what hospital he went to and would not be able to say he could not afford to go to a hospital and would, therefore, not have the incentive to go to a veterans hospital.

Secretary CELEBREZZE. Remember, without getting too deeply into the question of hospital insurance for the aged, there is no limitation in the bill as to what hospital the individual wants to go to. That is his own free choice. On the question of what doctor he wants to go to, that is his own free choice. The basic question involved if he goes to a veterans hospital and is entitled to treatment there, is whether the Veterans' Administration is to be reimbursed because he is covered under the social security program. I think that is one of the basic questions.

Mr. KEITH. I don't believe he would be eligible to go to a veterans hospital if he could afford to go elsewhere, as he would be under the King-Anderson bill.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Rogers.

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

Mr. Secretary, I notice you stated that during fiscal 1963 and 1964 a total of \$8.4 million of Federal matching funds have been appropriated to assist the States in the development of their comprehensive plan.

This is not a continuing fund. Isn't that true, on the planning? There is no further request at this time for additional planning funds, is that true?

Secretary CELEBREZZE. There is no request at all for planning funds.

Mr. ROGERS of Florida. You have met this need?

Secretary CELEBREZZE. Yes, we have. I think we are at the point now where the planning has moved ahead and they are ready to go

into construction, but the States are rather hesitant to go into this new area without some staffing help, at least for the first 5 years.

Mr. ROGERS of Florida. How many States have submitted their comprehensive plans to you as of the present date?

Secretary CELEBREZZE. Fifty States have already submitted interim progress reports. Of course, the deadline does not expire until the end of this year.

Mr. ROGERS of Florida. Yes, the end of this year is the deadline for that.

Secretary CELEBREZZE. Yes.

Mr. ROGERS of Florida. Just from your being in touch with them, how many do you anticipate will file by the end of the year?

Dr. YOLLES. They will all file reports on comprehensive mental health planning by the end of the year.

Mr. ROGERS of Florida. You anticipate that all 50 States will have filed by the end of the year?

Dr. YOLLES. Yes.

Mr. ROGERS of Florida. What is the amount estimated that you will need for staffing? I notice the bill, as drawn, authorizes whatever sums may be necessary in section 224?

Secretary CELEBREZZE. In the first year expenditure, we anticipate, for the staffing of approximately 65 centers, \$19.5 million, as an estimate.

Mr. ROGERS of Florida. And the overall program authority you are asking for would cost how much in your estimate?

Secretary CELEBREZZE. We don't have that figure.

Mr. ROGERS of Florida. There is no estimate?

Secretary CELEBREZZE. The bill refers to such sums as Congress may appropriate thereafter.

Mr. ROGERS of Florida. I realize that. I wondered what your estimate would be, though, as to what you think it might be. I realize this may not be exactly what will be required.

Secretary CELEBREZZE. We have not worked that up at all. We wanted to get our first basic year of experience and see how rapidly we were going. That was one of the reasons for leaving it as such sums as Congress may appropriate.

Mr. ROGERS of Florida. If the committee desired to put in a maximum limitation, could you submit those figures for the committee?

Secretary CELEBREZZE. It would not be the recommendation of the administration.

Mr. ROGERS of Florida. I understand.

Secretary CELEBREZZE. But if the committee asks us to cooperate in submitting figures to them, we will follow our usual pattern of completely cooperating with the committee.

Mr. ROGERS of Florida. As I recall, you did have estimates when you submitted the program 2 years ago.

Secretary CELEBREZZE. When we submitted it in conjunction with the other bills we had a total.

Mr. ROGERS of Florida. I recall very well the estimates. I thought I would be interested in seeing them and I would hope that your department would be able to give us these estimates if the committee decided they desired to have them.

I am encouraged that you have asked for the staffing to be phased out, and by the fact that you have actually phased out one program, your planning program.

Secretary CELEBREZZE. Yes. That has worked very well. I am hopeful this will work very well, too.

Mr. ROGERS of Florida. And it can also be phased out as you now anticipate?

Secretary CELEBREZZE. Let me say this. I know that a great many people wonder why one asks for staffing. We went through it pretty thoroughly in the last session. Again, I can only say that as a former local public official, the easiest thing then in the world for a mayor and sometimes a governor to do is to build a building.

They give you the bond money for it. But operating costs does not come out of bond money and you have to either increase your levy or increase your sales tax. There you have an extremely difficult time. In our planning, since we are going to get away from the large institutional care, we say that the State is going to be able to phase out some of its costs in these large institutions as these patients stay in their own local community but it will take a little time for them to do that.

Therefore, we are going to give them 5 years of assistance on a diminishing basis, from 75 to 60 to 45 to 30 percent of staffing costs. Meanwhile the responsible public officials or the legislature knows that they have that deadline to meet and they can make their adjustments.

But if you hit them all at once and say, "Here is a building" and you need \$10 million or \$5 million, or whatever the figure may be to operate it, they are rather hesitant to go into it. We are merely using this as an inducement in order to give them time to readjust their finances, because they are going to save money, and because in the last year or two there has been greater recognition by insurance companies to insure this type of thing, mental illness.

Therefore, you will have additional revenues available from the individual, himself, to pay for these. That is the reason we say for 5 years give them some assistance.

Mr. ROGERS of Florida. Mr. Secretary, could you submit for the committee, as I think you did before, your thinking on the suggested staffing of the community health centers, how many psychiatrists, aids, and so forth, would be required?

As I recall you set up a model staffing center for about 100,000 people. If that could be submitted for the record where we might have it, I would appreciate it, and then if you could have the estimates of what you anticipate the staffing will cost it would be helpful.

Secretary CELEBREZZE. We will furnish that for the record.

The CHAIRMAN. The hearings on this subject in the last Congress may become a part of this record by reference. I believe the information Mr. Rogers asked for was contained in the hearings.

You may bring that information up to date and include it in this hearing as requested.

(The documents requested follow:)

Staffing pattern of an average community mental health center

	Total number	Total cost
Psychiatrists.....	6	\$135,000
Psychologists.....	4	60,000
Social workers.....	6	60,000
Nurses.....	14	112,000
Psychiatric aids.....	24	120,000
Health educators.....	2	20,000
Occupational therapists.....	2	16,000
Total.....	58	523,000

In addition, approximately 14 supporting personnel including EEG technicians, lab technicians, X-ray technicians, dieticians, practical nurses, orderlies, at total cost of \$80,000.

The President's budget has included \$19.5 million for this program for fiscal year 1966. It is the Department's estimates that future year costs would look like this:

[In thousands of dollars]

Fiscal year 1966	Fiscal year 1967	Fiscal year 1968	Fiscal year 1969	Fiscal year 1970
19,500	16,575	12,675	8,775	1,950
-----	24,000	20,400	15,600	10,800
-----	-----	30,000	25,500	19,500
-----	-----	-----	36,000	30,600
-----	-----	-----	-----	42,000
19,500	40,575	63,075	85,875	104,850

NOTE.—Five-year total, \$313,875.

After 1970, when no new grants can be made, the program obligations, based on grants made prior to 1971, would diminish as follows:

Fiscal year 1971	Fiscal year 1972	Fiscal year 1973	Fiscal year 1974
\$2,400	-----	-----	-----
13,500	\$3,000	-----	-----
23,400	16,200	\$3,600	-----
35,700	27,300	18,900	\$4,200
75,000	46,500	22,500	4,200

NOTE.—4-year total, \$148,200; 9-year total, \$462,075.

The CHAIRMAN. Mr. Curtin.

Mr. CURTIN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Kornegay.

Mr. KORNEGAY. Thank you, Mr. Chairman.

Mr. Secretary, let me join my colleagues in welcoming you to the committee. It is nice to have you and members of your staff with us this morning.

Pursuing the point Mr. Rogers was making a few minutes ago, with reference to the phasing out of the planning stages of the program this year, I wonder how many of the 25 States which have already submitted plans have made requests for construction money.

Secretary CELEBREZZE. The construction funds on two State construction plans have come in.

Mr. KORNEGAY. I understand. I am talking about the bill passed in the 88th Congress, which provided, as I recall, money for construction of facilities.

Dr. YOLLES. Under Public Law 88-164 the States are required to submit a plan for construction. We expect that about 37 States will have that in by the close of business on June 30 of this year. Some of the States plan to submit their plan during the following fiscal year because the law allows a carryover of the first year funds into the second year.

Some of the States are somewhat behind in their comprehensive planning and would like to make this dovetail with their construction planning. But we have preliminary progress reports from many on their comprehensive planning which takes into account some of the construction needs as well.

Mr. KORNEGAY. That is what I am getting at. How many States have actually requested money for construction?

Dr. YOLLES. For construction?

Mr. KORNEGAY. Yes; for construction of facilities.

Dr. YOLLES. About 16 have indicated they would need funds, but this was hardly the document in which to request the funds. These were the preliminary reports on comprehensive planning. There are letters of intent to use the construction funds from at least 40 States.

Mr. KORNEGAY. Have any of those requests for construction funds been approved by the Department?

Dr. YOLLES. The request for construction funds cannot be approved until the State plan is approved. We are waiting for the submission of the State plans.

Mr. KORNEGAY. I understand you already have 25 States submitting their plans. What I am trying to get at is how far along are we in the program?

Dr. YOLLES. We are in the very early stages of the construction program. There is some confusion between the comprehensive plan that will be submitted for all services in the State on mental health and the construction plans required under Public Law 88-164.

The latter ones, the State plans for distribution of service facilities that they intend to construct, have not come in yet. The first two have arrived, but the rest are due in either by the close of this fiscal year or they again may be carried over to the next fiscal year.

We expect a large number of them in by the close of business on June 30 of this fiscal year.

Mr. KORNEGAY. But no facilities are under construction at the present time?

Dr. YOLLES. No, sir. The money became available to us in November and the State plans, which are mandatory by law, have not come in as yet. No application—individual application—can be approved until the State plan is approved.

Mr. KORNEGAY. What is the basis for the concern of the Department that the States will not go through with the construction of these facilities until they have some assurance that they will be aided in their staffing?

Secretary CELEBREZZE. In the course of our consulting and working with the States, we found 13 States have stressed to us the importance of receiving operational staffing funds in order to have an effective

program. There is a total of 26 States that have addressed themselves to it. I can furnish the States for the record, if you want them.

There are 10 States who have said they just can't go ahead and do this without additional staffing funds. There are six States which have said to us that they are severely impeded without Federal support.

There are 10 States that have said they just can't build these community facilities where they are most needed without some staffing funds. So we have inquiries along those lines from 26 States.

Mr. KORNEGAY. We, of course, went into the staffing provisions of the bill last time. As I recall it, the committee decided against it at that time. Mr. Secretary, do you feel that there is any element in this situation where eventually the Federal Government will provide staffing and for that reason the States are dragging their feet or are a little slow to come in?

Secretary CELEBREZZE. No. I think I am sufficiently close to local public officials and a few Governors to understand what their problems are at this time.

Mr. KORNEGAY. And again you and I, of course, both know that there are times when local and State officials will be a little slow to act if they feel there is a possibility that the Federal Government is going to come in and give them some financial assistance.

Secretary CELEBREZZE. There may be, but in most instances the local public officials and the State public officials want to meet a need of their people and they have only so many dollars.

They have priorities and they are hit from all sides, in the field of education and other programs, and they have to do what we do, give first priorities. They can't move in all directions the way they should be moving on a rather complex problem at this time.

Mr. KORNEGAY. I wanted to get your thinking as to whether or not this was an element in the fact that the States are rather slow to come in or have taken the position that they can't go ahead with the program unless the Federal Government guarantees a portion of the cost of the staffing.

Secretary CELEBREZZE. There have been some States, 10, which have indicated to us that they just can't move to go into the poorer sections of their States in order to do this. They have indicated that they have to have some help until they can adjust their finances in the next 4 or 5 years.

Mr. KORNEGAY. Has the proposal which you have made to the committee at this time been submitted to the States; that is, the aid in staffing on a diminishing basis?

Secretary CELEBREZZE. I presume the States know. We can't submit it to them because it has not passed yet. But they are aware of the legislation before this committee.

Mr. KORNEGAY. They are aware of the fact that this proposal has been made?

Secretary CELEBREZZE. Yes; they are aware of the phasing out phase of it.

Mr. KORNEGAY. Have those who have commented to you or corresponded with you about it expressed the feeling that this would be sufficient, that is, the plan that you have submitted?

Secretary CELEBREZZE. I have not talked to them directly. Dr. Yolles has talked to them directly.

Dr. YOLLES. There have been a few who have expressed the hope for a panacea and that the Federal Government would support the thing forever. But the vast majority of the States and the communities and, more importantly, the communities, since they are the ones who will be hurting in providing the matching funds for the construction and operation, are aware that this is a program that will be phased out and they are prepared to deal with that problem.

Mr. SPRINGER. Will the gentleman yield at that point?

Mr. KORNEGAY. Yes.

Mr. SPRINGER. Do you have any particular instructions which you will give if these grants are made that these things will be phased out, or is it just an understanding?

Secretary CELEBREZZE. At the time the grant is made? They will know they will be phased out. They have to raise their finances every year. The first year is 75 percent matching, the second year is 60 percent, the third year is 45, and the last year is 30.

They certainly will be informed as to what the matching grant will be; that there will be a diminishing amount each year.

Mr. SPRINGER. Mr. Secretary, you are probably going to be here for at least 4 more years. Will you guarantee me you won't come back in here, if I support this bill, 4 years from now asking for another extension of this?

Secretary CELEBREZZE. I am sure this Congress—and, after all, we can only suggest and Congress passes the law. What the circumstances will be at that time, I don't know. I wouldn't try to guess on conditions 4 years from now.

I am hopeful, based on past experiences, that it will phase out. On the other hand, we have had some experiences where things haven't phased out, so I wouldn't try to guarantee you about anything that would happen 4 years from now.

Mr. SPRINGER. It is just your intention to phase out this program as of this moment; is that correct?

Secretary CELEBREZZE. It is our honest intention. It is our honest belief, after consulting, that it will phase itself out, but what the conditions are going to be 4 years from now, I don't know.

If the program is working fine, if the communities have met their obligations, have gotten themselves squared away, I think if the results are there, in that we are relieving these things—you know, today with proper treatment we can take 50 percent of our people out of mental hospitals. Therefore, that is going to reduce their expenditures and I am sure that they can reallocate that money into these communities.

I believe the vast majority of public officials are honest when they tell you "Give us some help for 4 or 5 years."

Mr. SPRINGER. You are not going to come back in here during this 5-year period and ask for a change?

Secretary CELEBREZZE. As an administration? I don't know. Again, I wouldn't try to anticipate what problems we may run into in the next 5-year period. It is our intention in the program we are presenting to this committee to get this for the next 5 years and not ask for any more. What circumstances may arise, I don't know. I am trying to be fair in answering your question.

Mr. SPRINGER. That is a pretty big qualification.

Secretary CELEBREZZE. It is a big qualification because, too, Congresses change. It is hard to say what is going to happen. But as far as the administration goes in presenting this bill, it is our intention not to come back for an extension 5 years from now. This is the bill as we see it. We think this will do the job. Whether someone else will, I am unable to say.

Mr. SPRINGER. Thank you.

I thank the gentleman.

Mr. KORNEGAY. Mr. Springer asked the questions that I was leading up to, although I wasn't going to put it to you quite as hard as he did, in the form of a guarantee, but I was going to ask you if you would impress upon the States who receive grants for staffing under this program the fact that this is a law and as far as the position of the Department is concerned, you plan to hold to it and stick by it.

Secretary CELEBREZZE. That is right.

Mr. KORNEGAY. One of the things that I am concerned with, and I am sure a lot of other members of Congress are, is that this money, if this bill is passed, will be money that the Federal Government will have to borrow. I don't know the financial condition of all the States, but I know in my own State of North Carolina there was a \$110 million surplus in the last biennial.

That is the point I want to emphasize. I supported the bill last year for construction of facilities. I think it is a good program. But we want to get it into the hands of the States and let them operate it as quickly as we can.

I also recognize the tendency on the part of State and local officials that is someone in Washington will pay the bill, it is the easy way out for them. I am not criticizing or complaining, but it is the fact of life.

I yield to the gentleman from Florida.

Mr. ROGERS of Florida. It is true, isn't it, that this committee wrote into the law that your planning grants, for instance, would be in existence for so long, and you would hold faith there and not come in and ask for additional funds?

Secretary CELEBREZZE. That is our intention, Mr. Rogers, but I, as an individual, can't say I guarantee something will not happen 4 years from now.

Mr. ROGERS of Florida. I understand.

Mr. KORNEGAY. That is all.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. Under the authority of the Department, in the past you do use a formula or a set of criteria in awarding construction grants for the construction of these mental health facilities; is that correct?

Secretary CELEBREZZE. Yes.

Mr. BROYHILL. Pursuing the question Mr. Keith was asking you a moment ago, can you give us a little more specific information on the criteria or formula which you propose to use to award these grants for the staffing of these facilities?

Secretary CELEBREZZE. I will have Dr. Yolles answer that.

Dr. YOLLES. It is proposed that the staffing grants not be on a formula basis, but rather, be on a project-grant basis so that these funds can be administered flexibly, at least in the beginning of the program, and so that those communities that are ready to move forward and extend their services, and also those communities that are in most need can be assisted.

Mr. BROYHILL. How do you determine which community has the greatest need?

Dr. YOLLES. The States will assign priorities in review of their plans based on the need within each community. We will then, on the basis of the moneys which have been appropriated to us—the sum total of moneys appropriated to us—try to make some determination, on the basis of the needs presented by the States, as to which communities are ready to go now and which have the greatest need.

Mr. BROYHILL. Then we could anticipate a situation arising where one State would get quite a bit more than another State, and particularly as it applies to the formula you use in awarding the construction grants.

Dr. YOLLES. If you carried this to its logical extreme, yes, there could be a situation, possibly, where one State would get it all, but we are aware now, from comments that the States have made, that there are pockets of need in every one of the States. It is certainly not anticipated that the funds will be used in just one small area.

Mr. BROYHILL. Could you have a situation arise where one community would receive a 50-percent grant and another a 75-percent grant?

Dr. YOLLES. No, the grants will be equal. The Federal matching will be according to the formula presented before. It depends on what the community asks for in terms of its construction or what it is asking for at an already established service.

Mr. BROYHILL. Would you not anticipate that every community would ask for the maximum?

Dr. YOLLES. No, sir. We know that some places will be coming in to construct, say, facilities for an outpatient department which is missing, but the inpatient services, the transitional services, and the other elements of services, are already present. In other cases they may wish to build a ward in a general hospital to house psychiatric patients. In the third case they may choose to build all of the facilities of the center, and the costs would be different in each one.

Mr. BROYHILL. I will yield to the gentleman from Massachusetts.

Mr. KEITH. Thank you.

On this same subject of formula versus outright control by the Federal Government, flexibility by the Federal Government does not necessarily mean flexibility by the State government. In fact, it could mean just the contrary.

I have a letter here from the Commonwealth of Massachusetts, the department of mental health, speaking, I think, specifically to Public Laws 88-156 and 88-164. Do those citations refer to the legislation under discussion here?

Dr. YOLLES. Public Law 88-164 is the Mental Health Centers Construction Act.

Mr. KEITH. So it does refer to what we are talking about. Here is the next to the last paragraph:

We feel strongly that each State undertaking a comprehensive analysis of retardation under the Federal program should be eligible for these funds on a noncompetitive formula-type basis. We hope you will concur.

Secretary CELEBREZZE. Is he talking about mental retardation or mental health? There is a difference under the Mental Retardation Act and Mental Health Act. You can't tie these two together. Is he referring to mental retardation?

Mr. KEITH. In his initial paragraph he refers to Public Law 88-164.

Dr. YOLLES. Under Public Law 88-164 there is a formula-grant basis for distribution of funds to the States for construction of community mental health centers. Public Law 88-164 also includes construction for other facilities, including those for the mentally retarded.

Secretary CELEBREZZE. May I say, Congressman, that Dr. Dempsey will clarify those points in his testimony.

Mr. KEITH. I don't want to pursue this any further at this time, but basically we do trust our States to exercise the flexibility which we think the program needs within our districts.

Secretary CELEBREZZE. Our policy has always been to leave as much flexibility with the States as is consistent with the enabling legislation passed by the Congress. In almost all of our programs, which are State programs, we have had amicable relationships in trying to achieve the objectives set forth in the legislation enacted by the Congress.

You will always have a variance of opinion in many groups, but we try to hit the consensus on it and cooperate as much as possible.

Mr. KEITH. Thank you.

Mr. BROYHILL. Getting back to my question, do I understand your answer to my question was that the grants would go to the communities which can show the greatest need?

Dr. YOLLES. That is one criterion, and the other would be those who are ready to use the funds.

Mr. BROYHILL. Will you be providing any guidelines to the State so that they can make this determination in an orderly fashion?

Dr. YOLLES. The act would require that the Secretary promulgate regulations, much as was done under the Construction Act, and this would be the guidance for the States.

In addition, the Public Health Service provides consultation to the States on all programs.

Mr. BROYHILL. Thank you.

The CHAIRMAN. Mr. Rooney.

Mr. ROONEY. Mr. Chairman, I would like to thank the Secretary for his very informative presentation. I think the American people can be very happy that we have such an able and capable and dedicated individual heading this very important department.

It is my hope that you will be back here in 4 years, Mr. Secretary.

I do have one question on H.R. 2984, the controversial section 4. I didn't know your department was so overworked and understaffed. I was just wondering how much these additional Assistant Secretaries will cost.

Secretary CELEBREZZE. Dr. Dempsey's salary will be increased about \$1,000. So it would run in the neighborhood of about \$54,000 or \$55,000.

Mr. ROONEY. Thank you.

I have no further questions.

The CHAIRMAN. Mr. Harvey.

Mr. HARVEY. Mr. Secretary, section 221, subparagraph 3, of House bill 2985, limits the staffing grants to those communities that have already used construction grants. My question is how can you reconcile this with the previous statement of the doctor—

Secretary CELEBREZZE. No, if you read further, construction grants and to those who add a new service to those services in being. There are two classifications.

Mr. HARVEY. Either a construction grant or adding new services?

Secretary CELEBREZZE. Yes.

Mr. HARVEY. Isn't it conceivable that a community health center could already be having staffing problems and not do either, in other words, not received the construction grants or added a new service?

Secretary CELEBREZZE. Here our problem is to do something more than is already being done. This is for the purpose, as I tried to explain earlier, of stimulating the communities to add to what they are not already doing. The Federal Government says, "We will help you with the staffing grants."

Mr. HARVEY. I understand that, but I also understood just now in answer to Mr. Broyhill's questions, that the guidelines are for those communities who are ready to use the funds.

Secretary CELEBREZZE. Yes.

Mr. HARVEY. It would seem to me along that guideline that some of these communities that are having staffing problems from other matters would certainly be ready to use funds.

Secretary CELEBREZZE. Yes; if they come in with an improvement in their program, or show to our satisfaction that they are improving their program.

Mr. HARVEY. Maybe Dr. Dempsey will comment on this this afternoon, but isn't part of this the staffing problem directly related to the shortage of psychiatrists and trained personnel that all mental hospitals share?

Secretary CELEBREZZE. No. I will have Dr. Yolles address himself to the staffing problem, but there has been an improvement.

Dr. YOLLES. Will you restate your question?

Mr. HARVEY. My question is this: Isn't the staffing problem directly related to the shortage of psychiatrists and other trained personnel in the hospitals, and, therefore, isn't that a problem that all community center hospitals would share regardless of whether they are new ones or have added new services? They all share the same problem of having to pay higher wages and attracting new personnel to the hospitals.

Dr. YOLLES. Yes; there is a shortage of all the classes in mental health professions. But, as the Secretary mentioned before, there has been a continued growth over the years in the number of mental health professionals that have been produced in the Nation.

In 1960, there were a total of 44,000 professionals in the four disciplines in mental health, psychiatrists, psychologists, psychiatric social workers, and mental health nurses. By 1965, there were 64,000 of those professionals, and we estimate that there will be better than 87,000 by the year 1970.

We are making very rapid progress which is primarily due to the stimulation by the Congress of training programs which are supported by the Federal Government in all universities.

In addition to that, the development of the general practitioner training program in 1959 has enabled thousands of general practitioners to develop some of the elements of psychiatric training so that they can treat minor cases. This has added tremendously to the manpower pool.

In addition to that, as mentioned previously, the passage of the Health Professions Act will add to the future pool of mental health professionals, and all other medical professionals. New types of ancillary personnel have been developed in the last few years, other types of personnel to aid in mental health work, the use of volunteers has increased, the number of part-time professionals working in this field has increased, with many more coming out of private practice and working in public service than ever before.

For example, we ran a survey last year which showed that there has been a 2.5-percent increase in psychiatric aids in the State hospitals, and this has been heartening.

Furthermore, as the number of resident patients in State mental hospitals come down, and they have been coming down for the last 9 years in very startling fashion, and as we approach in these hospitals a more optimal staffing ratio than we presently do have now, and as patients continue to decrease, many of these personnel will be transferred to the community mental health centers which we hope will be constructed by that time, and again lessen the shortage of manpower.

To this end we have already trained under other appropriations, 22,000 of these subprofessional personnel in mental hospitals. So we are making inroads on the staffing problem.

Mr. HARVEY. Thank you, Dr. Yolles. I have other questions to direct to Dr. Dempsey later when he testifies.

The CHAIRMAN. Mr. Murphy.

Mr. MURPHY. I would like to thank the Secretary for being here today and for presenting his brilliant statement. He speaks particularly from a vast range of experience in municipal and State affairs and has come up with a comprehensive piece of legislation.

I know some States, particularly the more affluent States, have made great strides in meeting their mental health problems, and I don't think, as the Secretary indicated, we can put this legislation in the same vien as a Federal aid highway program, where we actually reimburse States for early participation. I think, as the Secretary pointed out, the thing to do is to move forward from the gains we have now and to stimulate in the less affluent areas the meeting of this critical mental health problem.

The CHAIRMAN. Dr. Carter.

Dr. CARTER. This has certainly been an excellent presentation, Mr. Secretary, and I am very happy to have you before the committee today.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Satterfield.

Mr. SATTERFIELD. Thank you, Mr. Chairman. I would like to apologize for being late. I had to be at another committee meeting.

The question I want to ask may already have been asked, and, if so, I don't want to take the time for it now. I am interested in the projected cost under H.R. 2985 throughout the length of its applicability.

Secretary CELEBREZZE. Mr. Rogers has asked that question.

Mr. SATTERFIELD. Thank you very much.

The CHAIRMAN. If I understand, the question was, What is the projected cost of the proposed staffing?

Mr. SATTERFIELD. Yes.

The CHAIRMAN. \$19.5 million for the first year, which would be 75 percent. That would be for a period of 15 months. For each year

thereafter, making the total program 4 years 15 months, it would be graduated: 60 percent for the second year—that is, the first year after the 15 months—45 percent the next year, and 50 percent for the final year.

Mr. ROGERS of Florida. Except all of the new centers would not come in in the first year, I don't believe. I think there would be more coming in in each of the 4 years, probably. But these are going to increase the estimates, I believe.

The CHAIRMAN. That is assuming that the 65 centers would be the approximate program. I assume there would be more centers as time went on. Is that right?

Secretary CELEBREZZE. Ultimately we are talking in terms of 400 to 500 centers. That is the projection, 400 to 500, or possibly more. So the \$19.5 million is gaged to our anticipated 65 centers in the first year.

The CHAIRMAN. We have asked for a breakdown of those centers, together with the approximate personnel that would be involved.

Mr. Ronan?

Mr. RONAN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Mackay?

Mr. MACKAY. Thank you, Mr. Chairman.

I would like to express appreciation to the Secretary and his Department for the leadership they have given in this field. I am no doubting Thomas, because I have come here from the Georgia Legislature and I have seen the validity of this program in reducing the number of people in our State hospitals and the efficacy of treatments in a community center.

I was interested in your remark that people are very ready to build a new building. It is very popular to say, "Let's get these people out of the firetrap," but it is a little higher hurdle to say, "Let's get this new building staffed with people to get them out of the mental hospital."

I know some questions have been raised here as to whether or not you can phase out this program. I believe that you can, based on our experience in Georgia, and I believe our people are going to be in here to testify before this committee. But in my opinion, the leadership that the administration is giving here has changed the picture which was medieval to one which was very modern. I would just like to express my gratitude for what has been done under this act already, and also my belief that this staffing is essential if this program is to move forward.

Secretary CELEBREZZE. Thank you.

Mr. MACKAY. I wish this committee could visit the Georgia center. I think to visit a big mental hospital and then go to a community health center is the most convincing way to make the case for this sort of bill.

Secretary CELEBREZZE. I think that the outcome of all of this has been to focus the attention of the public not only on mental health but on other areas of disease—mental retardation, epilepsy—that these are diseases and we don't have to keep these people in dark rooms anymore. We can do much in either curing them or helping them toward a better life.

The fact that the public now acknowledges that there is nothing to be ashamed of about a mental patient, and that we are trying to find

solutions, and not only solutions but means of preventing mental illness, that has been the great gain.

Because of that awareness we are making great progress.

The CHAIRMAN. Mr. Gilligan.

Mr. GILLIGAN. Mr. Chairman, I can only say that Ohio is proud to produce men of such great stature as the Secretary, a man of such great ability and with still some ambition.

Several of the members of the committee have inquired about the possibility under this program of penalizing States that have gone forward vigorously with their own programs of mental health. I would like to ask a question on the other side of the issue. I think the distinguished Secretary and I both know of a State which has, within the last 2 years, made a 10-percent cut across the board in its mental health program.

What guarantee have we that these staffing funds, if granted, would not be simply used by a parsimonious administration in a wealthy State to replace dollars cut out of State mental health budgets?

Secretary CELEBREZZE. The protection under the bill is that you have to increase your services in order to get a grant.

Mr. GILLIGAN. But you could begin new services, if I understand the language of the bill, while at the same time having an absolutely dismal situation in your existing State institutions, being understaffed to the point that they are in worse condition than they were 5 years ago.

Secretary CELEBREZZE. Well, they would have to comply both in showing an improvement and with the regulations as prescribed by the Secretary.

At this moment, I cannot give those to you.

It seems to me the question that you are propounding to me, Mr. Gilligan, is if a State has reduced their expenditures under the mental health program, because they didn't have sufficient funds to carry on their programs, or for other reasons—would the Federal funds provided when this law is enacted merely replace State dollars. I am going to turn that question over to Dr. Yolles.

Dr. YOLLES. I would just like to comment on one point, that this is a program to aid in the development of community mental health services, to the end which we all devoutly wish to see, the reduction in the size and eventual disappearance of the State hospital as we know it today. There is no direct link between the community program and the State hospital program.

I am sure the States could do this, possibly, if they so desired. But we are concerned with developing regulations. We have no concern or any authority over the State mental health institutions, except that we are working desperately at the present time, during this interim period when we are trying to develop community mental health centers, to improve the care and treatment in the State mental hospitals.

We feel very strongly, as the Secretary does, that no American in 1965 should be treated the way some of them are in some State institutions. Consequently, under other appropriations, we have made grants to State hospitals for improvements in the care and treatment, for demonstrations, of improved patient care by the most modern methods, new developments in community mental health. There is a parallel program to train the staffs of these hospitals to the

end that during this interim period while we are trying to move services to the community, that the patients in these hospitals will have better treatment.

But the two programs are not linked beyond that.

Mr. GILLIGAN. Granting that for the moment, Doctor, there would still be this point: I have been for some years on the board of trustees of the central clinic, the psychiatric clinic, in Cincinnati. This is one of the largest outpatient psychiatric clinics in the world, and the largest psychiatric training program in the world. In fact, they sometimes refer to Cincinnati as the Vienna on the Ohio.

But our experience has been in attempting to get funds for a community effort in mental health which is really regional in scope and embraces communities in three States, really, in a very tightly circumscribed area, that we are getting more funds, or we were, in the form of Federal research grants which helped us staff this facility.

We were getting more funds, although it was very tough getting them, from the United Appeal Agency, and at the same time the State allocations to this program were being cut back. So what we were able to get from the Federal Government in the form of research grants or from the United Appeal was, in a sense, offset by the unilateral cutback at the State level.

I am wondering, in the comprehensive plan that you require of the State, if you do require some real evidence that this is not just the robbing Peter to pay Paul, or moving dollars from one pocket into another to make a State administration look good, but that you are really requiring a good, vigorous effort within the capacity of that State to provide first-rate mental health services.

Dr. YOLLES. We would look very carefully at these same plans to see that that did not happen. I know the problem you speak of. I am an alumnus of central clinic. I know very well the problem you speak of.

Mr. GILLIGAN. Thank you, Mr. Chairman.

The CHAIRMAN. In order to make the record perfectly clear, Mr. Secretary, insofar as you know, and insofar as you can see at this time, this is the program that is proposed, which is part of the President's program. The intention is to provide staffing, as proposed in the bill, as you have explained, to be graduated out at the end of 4 years and 3 months.

Secretary CELEBREZZE. That is accurate.

The CHAIRMAN. That is the program.

Secretary CELEBREZZE. Yes.

The CHAIRMAN. And States which benefit by it are put on notice as to what you have stated as the intention and what the legislation, itself, includes, and, therefore, they are to be guided accordingly.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. Let me thank you again on behalf of the committee for your testimony here this morning.

Dr. Dempsey, you can see that it has been a full morning with the Secretary. That is the reason I suggested this procedure. If you can be back in the morning at 10 o'clock, you may continue with the presentation you had prepared for this morning.

The committee will recess until 10 o'clock in the morning.

(Whereupon, at 12:15 p.m., the committee recessed to reconvene at 10 a.m., Wednesday, March 3, 1965.)

RESEARCH FACILITIES, MENTAL HEALTH STAFFING, CONTINUATION OF HEALTH PROGRAMS, AND GROUP PRACTICE

WEDNESDAY, MARCH 3, 1965

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met at 10 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will come to order.

This morning we will resume the testimony from the Department of Health, Education, and Welfare. Dr. Edward Dempsey will present a statement, as suggested by the Secretary when he was here.

Dr. Dempsey, you may proceed.

STATEMENT OF DR. EDWARD W. DEMPSEY, SPECIAL ASSISTANT TO THE SECRETARY (HEALTH AND MEDICAL AFFAIRS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. FRANCIS SCHMEHL, CHIEF, HEALTH RESEARCH FACILITIES BRANCH, DIVISION OF RESEARCH FACILITIES AND RESOURCES; DR. STUART SESSOMS, DEPUTY DIRECTOR, NATIONAL INSTITUTES OF HEALTH; DR. LUTHER TERRY, SURGEON GENERAL, PUBLIC HEALTH SERVICE; AND DR. HAROLD GRANING, CHIEF, DIVISION OF HOSPITAL AND MEDICAL FACILITIES, PUBLIC HEALTH SERVICE

Dr. DEMPSEY. Thank you, Mr. Chairman and members of the committee.

I would like to introduce first, if I may, Mr. Chairman, the gentlemen at the table with me. You all know the Surgeon General, Dr. Terry.

On my right is Dr. Stuart Sessoms, the Deputy Director of the National Institutes of Health, and on my far right is Dr. Francis Schmehl, the Chief of the health research facilities group of the Division of Research Facilities and Resources at the National Institutes of Health.

The CHAIRMAN. Thank you, gentlemen; we are glad to have you.

Dr. DEMPSEY. I am pleased to present the views and recommendations of the Department of Health, Education, and Welfare on H.R. 2984, the Health Research Facilities Amendments of 1965, H.R. 2986, the Community Health Services Extension Amendments of 1965, and H.R. 2987, the group practice facilities bill. I shall speak first to the health research facilities bill, H.R. 2984.

The first part of this bill involves matching grants for the construction of health research facilities. The program of matching grants for the construction of health research facilities was first authorized by the Congress in 1956 with an annual appropriation authorization of \$30 million. It has been extended three times. The annual authorization has been increased to \$50 million.

Since its inception, 1,263 construction grants totaling about \$320 million have been awarded to 399 institutions in every State of the Union, the District of Columbia, and Puerto Rico. The total cost of the laboratories built with support from this program has exceeded \$800 million; so that for each Federal dollar spent, more than \$1.50 has been provided locally.

Under present authorization, this program will expire on June 30, 1966, and authority to accept applications terminates on July 1, 1965. Therefore, to continue this program without interruption, its extension must be authorized this year.

We believe the extension and increase in authorization provided for in the bill now before the committee to be essential for our national medical research effort.

The great postwar expansion in our medical research effort has been made possible by the progressive collaboration of Federal agencies and non-Federal universities, medical schools, and other research institutions. The health research facilities construction program has contributed substantially to the improvement and expansion of the research space which these institutions have provided for this national effort.

However, the funds available under the current health research facilities construction program have not been adequate for the best development of space and facilities to house our national and institutional programs. This program has had a continuous backlog of approved applications unpaid because of the limited funds available under the current authorization.

At the present time, the failure of the construction of health research facilities to keep pace with expanded research and research-training programs is a bottleneck to the further development of the Nation's capability for health research. The present imbalance among the components of an effective research effort needs to be corrected. This bill would go far toward meeting this urgent need by authorizing the further appropriation of \$400 million over a 5-year period.

The demand for health research facilities is far from static. We should anticipate continued expansion of medical research. The advancing age of the population and the growing load of debilitating and chronic diseases have created new demands for increased research efforts against heart disease, cancer, stroke, mental impairment, and other major diseases.

The passage of the Health Professions Educational Assistance Act of 1963 is a factor in increasing the demand for health research facilities. This act has encouraged establishing vitally needed new medical schools, but the applications submitted by these schools dramatically show that research facilities are an essential and integral part of any medical, dental or other health professional school.

Thus the expansion of medical education in this country requires new research space; for without research facilities a new school cannot attract the faculty necessary for the instruction and inspiration of high-caliber students.

Other demands for new research facilities arise out of the rapid changes in the nature of medical research. Modern methods of research can bring to bear on major health problems the full array of new scientific techniques, but these new techniques often require additional space for the sophisticated instrumentation required.

Increasing demands are being placed on health research facility funds to provide highly specialized facilities that serve as resources for many disciplines within an institution, such as computer and bio-instrumentation facilities, clinical research centers, radioisotope laboratories, and facilities for germ-free animals.

These more exacting design requirements of laboratories lead to increased costs of laboratory construction as well as requirements for additional space to house the complex equipment. But this increasing sophistication makes obsolete the research facilities designed in a time when the techniques of science were less complex. Forty percent of the present medical research facilities of the country are estimated to be more than 20 years old. Many of these facilities are inadequate for modern research.

The continuation of this valuable program for 5 more years and the proposed authorization of \$400 million over that period are minimal and essential steps which must be taken to insure the continued progress of medical research.

CONSTRUCTION OF RESEARCH FACILITIES FOR NATIONAL AND REGIONAL PURPOSES

The present construction program needs new authority which would enable construction of research facilities urgently needed for important national or regional purposes and which are beyond the scope, capability, or function of individual institutions.

The experience of the National Institutes of Health in encouraging research in the important field of aging has led to the firm conclusion that the only way to mount a truly effective research program in this field will be through establishing a series of major national laboratories on aging.

Productive research programs in this complex field must combine a number of scientific disciplines and research activities in a manner different from the usual departmental framework of a university or medical school. We are convinced that the contributions of the several scientific disciplines involved in aging can be substantially increased by providing specially designed research facilities permitting their organization into a cohesive program of laboratory, clinical, and field studies.

A research area such as that in aging, so important in its potential benefits, should not be dependent solely upon the initiative of non-Federal institutions or upon their access to matching funds.

The Department has long been concerned with the problem of enlarging the national research effort in the complex problems encompassed within the fields of toxicology and pharmacology which are so crucial to understanding the phenomena of adverse drug reaction, the effect of pesticides, and the broad problems of atmospheric and water contaminants. This is a research area which demands substantially greater effort than is possible within the present academic institutions engaged in this activity.

We need to undertake the development, in association with universities, of several major research centers which can bring to bear the diverse capabilities resident in schools of medicine, pharmacy, agriculture, and veterinary medicine in a new, combined scientific attack upon the solution of the complex problems involved in the effects of exogenous agents upon man. The development of these centers, since they are beyond the scope and capability of individual institutions, demands a national construction effort.

This proposed authority might also be appropriately used for the construction of facilities that could serve as a research resource for a number of institutions within a region. It does not seem reasonable to use a matching grant for such regional facilities, for this would require a single institution to commit sizable amounts of its own funds to serve the needs of an entire region or, indeed, of other institutions within the region.

The further advance of the biomedical sciences will certainly present additional needs to provide research facilities which are clearly beyond the capability or responsibility of individual institutions.

In order to provide flexible means for achieving such research objectives identified on the national or regional level, this bill contains authority to construct or to finance the construction of health research facilities when a determination is made that such construction cannot be effectively or appropriately financed through a matching grant.

The authority also provides, by contract or otherwise, for the operation of such facilities or for contributions toward the cost of the operation of similar facilities already constructed. It would also authorize transfer of title of any facility constructed under this authority to any public or nonprofit institution, subject to appropriate conditions for the protection of the national interest.

While authority of this type is new, similar authority has long been available to other major Federal research-supporting agencies, including the National Science Foundation, the Department of Defense, and the Atomic Energy Commission.

It is our firm conviction that the importance of research in the sciences related to health demands that the Department have available the same range of authority that has proven so useful in the conduct of other Federal research programs.

CONTRACTS FOR RESEARCH

The bill would authorize the Surgeon General to enter into contracts for research and also make available certain research contract authorities which are presently available to the Department of Defense, and comparable to those utilized by the Atomic Energy Commission and the National Aeronautics and Space Administration in the conduct of their research activities.

The Public Health Service Act, as it now stands, does not provide authority for the making of research contracts in the conduct of the Service's research programs. The research contract authority utilized by the Public Health Service is based on "point-of-order" language which appears annually in the appropriation statute. Thus, authority is inadequate in the present-day circumstances under which research programs are being conducted.

Progress in the biomedical sciences now makes possible the undertaking of deliberate developmental and applied research activities. The development of vaccines for respiratory diseases, the furtherance of research in the viral etiology of cancer, and the design and development of artificial organs such as the mechanical heart and the artificial kidney, are examples of the current direction of research activities which progress in the basic sciences has made possible.

The conduct of programs of this character requires greater control over the course of the technical activity and access to new kinds of engineering and scientific talent. Broader contract authority is essential if the Department is to move effectively in this area and to make broad use of the competency of industry in expanding research and development in emerging new areas important to our health programs.

The first of these authorities would permit payment of the costs of construction determined to be necessary in the performance of a research contract. Some research contracts require highly specialized facilities as an integral part of the research program. A current example is the special protective facilities required for continued work with dangerous and infectious agents encountered in the important research effort investigating the cancer-virus relationship.

Without such authority, these research contracts must be administered within restrictions based on superficial distinctions between temporary and permanent improvements. These artificial distinctions result in the expenditure of additional money with no productive effect on the performance of the contract.

The second authority requested would provide for the indemnification of contractors against claims which arise out of direct performance of the contract and which are the result of a risk which the contract defines as unusually hazardous. This type of contract provision is often required if a contractor is to be induced to undertake work which involves the handling of live viruses or the exposure to poisonous compounds.

As I mentioned before, this authority has been available to the Public Health Service for a number of years through point-of-order language in the Appropriation Act.

In our attack upon major health problems, we are now moving toward new efforts to expand scientific inquiry into problems of community health activity, into the urgent dangers of growing environmental hazards, and toward the realization of the national objectives so magnificently stated in the President's health message.

The three portions of this bill which relate to research authority constitute essential enlargement of the capability of the Department to assure strong advance in these areas.

I will now turn to House bill 2986, the Community Health Services Extension Amendments of 1965.

This bill would carry out recommendations made by President Johnson in his health message of January 7, 1965, for extending and otherwise amending certain expiring provisions of the Public Health Service Act relating to community health services.

The current programs which H.R. 2986 would extend are those relating to community immunization activities, health services for migratory workers, general public health services, and special project grants for community health services. I will discuss each of these programs briefly.

IMMUNIZATION PROGRAMS

For the past 3 years, funds have been authorized and appropriated under section 317 of the Public Health Service Act to assist States and communities in carrying out community vaccination activities against poliomyelitis, diphtheria, whooping cough, and tetanus. The legislative authorization for this program expires June 30, 1965.

Substantial progress has been made under this program in achieving a higher level of immunization against these four diseases. In addition, community programs have been developed which will maintain this level. As a result of these and other programs, the number of cases of poliomyelitis in the United States was reduced from 910 in 1962 to 121 in 1964; diphtheria from 444 to 306 cases in 1964; and tetanus from 322 to 271 cases in 1964.

During this period, an estimated 58 million people under age 50 received three doses of oral polio vaccine and 7 million children under age 15 were immunized against diphtheria, whooping cough, and tetanus.

I might say parenthetically that these figures from 1962 to 1964 give only part of the picture. As you all know, in the last 10 years the number of cases of polio has decreased from many thousands of cases per year to almost the vanishing point at the present time. This is one example of the effectiveness of these programs.

The CHAIRMAN. How many cases of polio were there last year?

Dr. DEMPSEY. 121.

H.R. 2986 would authorize an extension of Federal financial assistance in support of such programs for an additional 5 years. Despite the progress that has been made, the maximum desirable level of protection against poliomyelitis, diphtheria, tetanus, and pertussis has not been realized.

However, the major purpose of the extended authorization is to undertake a nationwide program of immunization against measles, one of the most infectious and serious of the childhood diseases. Approximately 4 million cases of measles occur in the United States each year, resulting in at least 500 deaths, and in extensive and serious disability, such as measles, encephalitis, mental retardation, pneumonia, and hearing disorders.

Safe and effective vaccines against measles have become available since the Vaccination Assistance Act was enacted in 1962. There is no longer any reason why measles should continue to take its toll.

H.R. 2986 would make Federal grant funds available by adding measles to the list of diseases against which federally assisted immunization programs are specifically authorized during the next 5 years.

H.R. 2986 would also authorize Federal grant assistance for vaccination programs directed against other serious infectious diseases for which effective vaccines or other preventive agents may become available during the 5-year period. This standby authority is specifically limited to infectious diseases which represent a major public health problem and which are susceptible of practical elimination through immunization programs. This provision in the bill would permit prompt action to achieve on a nationwide basis the advantages and opportunities of new vaccines which may be developed through medical research.

HEALTH SERVICES FOR MIGRATORY WORKERS

The second program which H.R. 986 would extend for an additional 5 years is the program of grants for family health service clinics, and other health services for domestic agricultural migrants and their families. The 3-year authorization for this program expires on June 30, 1965.

About 1 million persons, including workers and family dependents, move during each crop season in response to seasonal farm labor demand. They live and work for brief periods in nearly one-third of the Nation's counties. Their health needs are acute as a result of their low income, lack of education and understanding of good health practices, geographic isolation from communities and their health services, and customary ineligibility for the health care afforded indigent residents because they lack permanent resident status anywhere.

The Public Health Service has assisted 60 county or multicounty projects in 9 States and Puerto Rico. The projects vary from one locality to another in the nature and scope of their service. They provide medical treatment for illness or injury, immunizations, case-finding and treatment of communicable diseases, prenatal and postnatal care, and other preventive and curative services.

Family health service clinics to provide medical and, in some cases, dental care have been established in or near farm labor camps; public health nurses have been employed to visit families in the camps on a regular schedule; sanitarians have joined projects to work with the migrants themselves and with property owners to upgrade housing and environmental conditions; and health educators have been hired to work with the migrants to develop better understanding of modern medicine and good health practices.

In each of the first 2 years under the current authorization, the amounts required by applications approved for funding have exceeded the funds available. The amount available for grants in this final fiscal year is inadequate to fund all of the new applications on hand as of January 1st.

Major emphasis of the program will continue to be on early care to reduce the need for hospitalization. We do propose, however, making financial assistance available for costs of hospitalization in short-term general hospitals if:

- (a) Documentation of a problem in meeting hospital care needs is furnished;
- (b) A mechanism for furnishing early outpatient services and other preventive measures is part of the project; and
- (c) Assurance that payments for general hospital care from Federal grant funds will be only for migrants.

GENERAL PUBLIC HEALTH SERVICES

H.R. 2986 would extend, through June 30, 1967, the provisions of Section 314(c) of the Public Health Service Act which otherwise will expire on June 30, 1966. The Public Health Service now makes grants to States for the provision of general health services, mental health services, radiological health services, dental health services, and health services for the chronically ill and aged under this au-

thority. Also, under this authority, financial assistance to the 12 schools for public health is provided.

The purpose of the 1-year extension of this authorization is to permit a thorough study of the programs carried out under this authorization, and development of necessary legislative recommendations to increase their usefulness. In addition to studies which are being undertaken within the Department, the Public Health Service is also undertaking a joint review of legislative needs with the Association of State and Territorial Health Officers, and the State and Territorial Mental Health Authorities.

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

H.R. 2986 would also extend the provisions of section 316 of the Public Health Service Act for an additional 1-year period through June 30, 1967, pending completion for the studies which I have just mentioned. Under this section, which was enacted as part of the Community Health Services and Facilities Act in 1961, financial assistance is provided to States and other public or nonprofit private agencies to undertake studies, experiments, and demonstrations looking toward the development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons.

Under this program, the Public Health Service has been able, over the past 3½ years, to make grants for 187 projects in 40 States. With your permission, Mr. Chairman, I would like to provide for the record a listing of the project grants which have been made under this program.

The CHAIRMAN. I think it would be helpful to be included in the record.

(The document referred to follows:)

EXHIBIT A

SUMMARY OF APPROVED COMMUNITY HEALTH PROJECTS

I. ADMINISTRATION OF COMMUNITY PUBLIC HEALTH PROGRAMS

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH-40-37-A-63	University of Pittsburgh, Pittsburgh, Pa.; Joseph D. McEvilla.	May 1, 1963, to Apr. 30, 1966 (full-funded).	\$221,602

A project to establish a model system for the collection, storage, and retrieval of information relating to drug prescriptions. Recorded information from patients' prescriptions will be placed on magnetic tape for rapid retrieval to permit statistical studies of drug utilization, actuarial studies, market research studies of a retrospective nature, and studies of individual consumption and expenditures for prescribed medication. A long-range objective of the project is to permit retrospective studies of adverse reactions, as well as prospective studies on the health benefits and hazards of specific drugs within a known population.

PHS region	Project No.	Grantee and project director	Period	Amount
V.....	CH-24-10-A-64	United Community Services of Metropolitan Detroit, Detroit, Mich.; Mary K. Guiney.	June 1, 1964, to May 31, 1965--- Tentative.....	\$79,420 79,703 73,956

A program to take maximum advantage of the interrelationship between health, morale, and independence of aging persons who are living in their homes will be demonstrated and tested. The project will seek to develop methods of helping aging people maintain physical health while living in their own homes and to prevent, as far as possible, the development of health crises. It will determine whether there is a close interrelationship for aging persons between physical well-being, social well-being, and economic well-being.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-51-7-A-64	Washington State Department of Health, Olympia, Wash.; Bernard Bucove, M.D.	Jan. 1, 1965, to Dec. 31, 1965--- Tentative-----	\$32,478 32,432 33,661

The overall objective of this project is to demonstrate the value of epidemiologic services in improving chronic disease control programs in the State of Washington. The health department will establish a section on noncommunicable disease epidemiology which will conduct epidemiologic investigations designed to develop new and applicable knowledge, in response to requests from persons or agencies with chronic disease control program responsibilities. Project evaluation will be based mainly on the extent to which the work of the section can be shown to have made contributions to improved control programs.

PHS region	Project No.	Grantee and project director	Period	Amount
National	CH-55-11-A-64	Southern Branch, APHA, Birmingham, Ala.; George A. Denison.	Apr. 15, 1964, to Apr. 14, 1965 (1 year only).	\$47,548

This is a 1-year planning program to develop a 3-year demonstration program of inservice training at the undergraduate level to increase the knowledge and skills of those without formal training already employed in public health. The purpose is to upgrade community health services especially for the chronically ill and aged. Methods and course material will be developed by the project. Plans developed should lead to sound methods for conducting effective inservice public health educational programs.

II. STUDIES OF PEOPLE'S ATTITUDES TOWARD HEALTH PROGRAMS

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-38-A-63 CH-40-38-B-64	Allentown Hospital Association, Allentown, Pa.; Charles P. Sell, M.D.	July 1, 1963, to June 30, 1964--- July 1, 1964, to June 30, 1965--- Tentative-----	\$24,050 7,600 2,000

A project for a coordinated home-care program throughout Lehigh County to be provided by the Allentown Hospital Association in cooperation with other community agencies. The primary objectives are to provide such care to urban and rural patients who have received their initial care in the hospital; to find out why physicians do or do not refer patients for home-care services; to train physicians and paramedical personnel through this program; and to provide home-maker services from the hospital staff nursing aids. Comprehensive services will include medical care, nursing, physical therapy, speech therapy, home-making, nutrition consultation, medical social service, lab service, and transportation as indicated in each case.

III. TRAINING AND UTILIZATION OF PERSONNEL

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-21-3-A-64	Bingham Associates Fund, Boston, Mass.; George J. Robertson, M.D.	July 1, 1964, to June 30, 1965... Tentative-----	\$62,705 { 62,826 64,122

In this project an attempt will be made to upgrade medical care in the State of Maine through the use of open-circuit television. Television is a possible medium for bringing the teaching programs of university hospitals to the practicing physicians who do not take part in established postgraduate educational programs, but who are most active in out-of-hospital care such as home care, nursing-home care, care of the aged and the chronically ill and disabled. Educational TV facilities are available and can reach over 90 percent of Maine's physicians. A series of 16 one-half hour presentations yearly is contemplated. Evaluation of television as a method of postgraduate education will be included as a research portion of the project.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-32-5-A-63----	New Jersey Tuberculosis & Health Association and the Hospital Center at Orange, Orange, N.J.; Earl F. Hoerner, M.D.	Feb. 1, 1963, to Oct. 31, 1964 (full funded).	\$59,498

A project to demonstrate the feasibility of a comprehensive program of medical care and rehabilitation for unhospitalized patients with chronic respiratory disabilities. A regional teaching facility will be established to provide training opportunities for professional personnel in evaluation, treatment, and rehabilitation of the respiratory disabled. It is also proposed to demonstrate the value and adaptability of this program as a community service in other areas of New Jersey.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-2-A-62 CH-34-2-B-63 CH-34-2-C-64	Montefiore Hospital, New York, N.Y.; George A. Silver, M.D.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$40,000 40,000 40,000

A project to demonstrate a comprehensive training program for planners and operators of coordinated home-care programs. Through expansion of the home-care program of the hospital, selected professional health personnel are to be trained in organizing and operating home-care programs. Both short-term and long-term training is made available for several types of trainees, including community leaders who are expected to stimulate and influence coordinated home-care services. The chief focus of the training will be to orient the trainees in proper utilization of community resources to meet homebound patients' needs, with particular reference to home-care services.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-14-A-63	Visiting Nurse Service of New York, New York, N.Y.; Miss Anna Fillmore.	Nov. 15, 1962, to Dec. 31, 1963 (1 year only).	\$44,079

Support is given under this project for the production of an educational film to assist in preparing nurses for better understanding and improved care of the chronically ill and aged in their homes. The film will be produced by Vision Associates, Inc., New York, on a contract basis. Because of the increasing numbers of persons over 65 years of age with chronic illness and the trend toward

caring for them in their homes, it is felt that the film will be of assistance to agencies which are expanding their programs or developing new programs on care of the sick and aged at home and to schools of nursing, both in hospitals and universities. The Visiting Nurse Service of New York will be responsible for promoting wide distribution of the film either through the American Nurses Association, National League for Nursing Film Service, or through some other channel.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-25-A-63 CH-34-25-B-64	Jewish Home and Hospital for the Aged, New York, N.Y.; Frederic D. Zeman, M.D.	Sept. 1, 1963, to Aug. 31, 1964-- Sept. 1, 1964, to Aug. 31, 1965-- Tentative-----	\$20,050 20,535 20,535

This project will establish a training center within the Home for Aged and Infirm Hebrews of New York to prepare qualified health professionals to handle special problems of the aged and aging. Courses will be offered by the institution's professional staff as well as a group of invited faculty instructors utilizing other community agencies for demonstration purposes. Evaluation will be based on the enthusiasm with which the program is received by the personnel being trained.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-30-A-63 CH-34-30-B-64	Henry Street Settlement, New York, N.Y.; Mrs. Marion Kron.	July 1, 1963, to June 30, 1964-- July 1, 1964, to June 30, 1965-- Tentative-----	\$42,200 53,940 47,810

In this project a small professional staff will recruit, train, and supervise approximately 100 volunteers in a variety of health-assistance tasks. Referrals for service will come from nearby clinics and hospitals, public housing management, the Department of Welfare, private agencies and individuals. Help will be given to the homebound with light housekeeping, shopping, and meal planning. Escort service will be provided in connection with outpatient treatments, and home visits will be paid to convalescents and incapacitated. A participant-observer will record and analyze referral and training procedures and evaluate services rendered. An advisory council representing area agencies will review progress and guide activities.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-43-A-64 CH-40-43-B-65	Montefiore Hospital Association of Western Pennsylvania, Pittsburgh, Pa.; Mrs. Celia R. Moss.	Jan. 1, 1964, to Dec. 31, 1964-- Jan. 1, 1965, to Dec. 31, 1965-- Tentative-----	\$39,215 42,845 39,671

This project will establish a training and information center for home care and related community services for the chronically ill for planning, developing, conducting, and evaluating a series of educational experiences toward providing orientation in the establishment, operation, and improvement of coordinated home-care programs and related out-of-hospital services. The program will be geared to multidisciplinary groups as well as individual professions. Methods will include courses in teaching specifics, planned institutes, seminars, and workshops.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-44-A-64	University of Pittsburgh, Pittsburgh, Pa.; Frances L. Drew, M.D.	Oct. 1, 1964, to Jan. 31, 1966-- Tentative-----	\$24,677 25,049 25,420

Because the medical student's horizon of illness is being increasingly limited to the clinic or hospital setting surrounding a patient, the objective of this project is to improve the understanding of these students about certain aspects of chronic disease. The medical student usually has little appreciation of the fact that patients return to a social setting which may importantly influence the course of the disease. He often delegates to the social worker the job of agency referral, often never discovering which agencies were chosen and why, nor what agency functions and limitations may be, and while he has the opportunity to study the diagnostic and therapeutic aspects of chronic disease, its social, financial, and epidemiologic aspects are ignored. Training will consist of observations of various community health problems and programs, field placement, and a written report of a study conducted during the training period. Evaluation will be based on the number of students seeking training, the content of the training experience, the quality of the student projects, and the amount of service performed for various community agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-09-3-A-63 CH-09-3-B-64 CH-09-3-C-65	George Washington University, Washington, D.C.; Frederick H. Gibbs.	Jan. 15, 1963, to Jan. 14, 1964-- Jan. 15, 1964, to Jan. 14, 1965-- Jan. 15, 1965, to Jan. 14, 1966--	\$74,958 83,914 77,669

The university will develop criteria and text material for a program of instruction of nursing home administration personnel by correspondence. The general purpose will be to develop courses which can be undertaken in many locations throughout the Nation with an aim to providing students with administrative understanding which might help them meet the standards required by the States in which they are located. Also to be developed is a screening test for applicants which will give an inclination of the level of instruction which should be offered, and a methodology for evaluating the text used and the instructional methods employed.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-41-3-A-63 CH-41-3-B-64 CH-41-3-C-65	University of Puerto Rico, San Juan, P.R.; L. E. McKelvey.	Feb. 1, 1963 to Jan. 31, 1964---- Feb. 1, 1964, to Jan. 31, 1965--- Feb. 1, 1965, to Jan. 31, 1966---	\$73,047 66,123 57,819

This project will investigate and evaluate the dental health care requirements of the people of Puerto Rico and formulate an effective plan to provide such services. It will be a pilot project to be used as an example to establish like facilities and procedures in all municipalities in Puerto Rico. Personnel will be trained at the University of Puerto Rico and will then form the nucleus to staff succeeding facilities.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-52-10-A-65	West Virginia State Department of Health, Charleston, W. Va.; Eugene J. Powell.	Jan. 1, 1965, to Dec. 31, 1965--- Tentative-----	\$17,910 15,100 11,200

This project will be a study to improve the quality of emergency transportation and immediate care available to the sick and injured, the study to cover all 55 counties of West Virginia. The first phase will determine the current status of emergency transportation, the second phase will consist of a training program to be developed and conducted by the staff of West Virginia University Medical Center in cooperation with the sponsor and other nonofficial organizations to raise the training level of ambulance drivers and crews. The third phase will consist of continuing educational efforts and development of a demonstration program for emergency services in a well-organized community selected on the basis of the survey.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-45-8-A-65	Outlook Nashville, Inc., Nashville, Tenn.; Mrs. Elsa T. Ellis, A.C.S.W.	Nov. 1, 1964, to Oct. 31, 1965-- Tentative-----	\$30,402 29,130 29,525

This project will recruit and train nonprofessional teenagers and adults to provide appropriate homemaker services to persons who are handicapped. Basic and advanced training courses will be standardized, with a flexible outline of content which can be adjusted to community resources as well as to range of age and intellectual and cultural levels of understanding of the trainee. The prime objective is to help the trainee feel more comfortable around persons who are physically, mentally, or emotionally "different," through development of a greater understanding and acceptance of the individual as a person, with the disability being seen in its proper perspective. The ultimate goal of the project is to demonstrate the value to a community when trained nonprofessionals are made available to all handicapped persons who might benefit from their services.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-24-4-A-63 CH-24-4-B-64 Supplement B-65	University of Michigan, Ann Arbor, Mich.; Vlado A. Getting, M.D.	Apr. 1, 1963, to May 1, 1964--- May 2, 1964, to Apr. 30, 1965--- Tentative-----	\$30,824 29,447 2,000 32,007

This project will establish a training program in home care as a joint endeavor of the University of Michigan School of Public Health and the Visiting Nurse Association of Detroit. The training program will consist of four 4-day institutes in each of 3 years. Materials developed will be published, and later developed into a training manual which should be of value to communities interested in developing home care services in the future.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-21-A-65	University Hospitals of Cleve- land, Cleveland, Ohio; Dr. Malcolm S. Mackenzie, Mrs. Mary F. B. Mohammed, R.N.	Award not issued as of Dec. 31, 1964.	\$43,916 36,322 25,544

The project objective is to write programed instructional material for persons with diabetes mellitus, administer it to a selected group of patients, and evaluate its effect on diabetes control, patient learning, and patient attitude. The proposed programed instructions will incorporate the actual performance of the desired behavior as an integral part of its structure in the expectation that this may lead to improved self-care and control of the diabetes, as well as to an increased knowledge of the facts about diabetes. Evaluation of the programed course will be through trial use, item analyses, and revisions.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-53-4-A-65	Wisconsin State Board of Health, Madison, Wis.; Mil- ton Feig, M.D.	Oct. 1, 1964, to Sept. 30, 1965-- Tentative-----	\$48,091 51,741 44,435

The Wisconsin State Board of Health will develop and conduct a 4-month course to train certified occupational therapy assistants as activity program directors in nursing homes. The course will follow guidelines established by, and will seek the approval of, the American Occupational Therapy Association. Priority for admission will be given persons presently functioning as activity program directors, with second and third priority given other employees of nursing homes.

and unemployed persons, respectively. After thorough evaluation of the project, if a need for continuation of the course has been demonstrated, it will become an integral part of the State board of health program activities.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-27-1-A-62 CH-27-1-B-63 CH-27-1-C-64	Jewish Hospital of St. Louis, St. Louis, Mo., Franz U. Steinberg.	Sept. 1, 1962 to Aug. 31, 1963... Sept. 1, 1963 to Aug. 31, 1964... Sept. 1, 1964 to Aug. 31, 1965...-	\$45,367 49,173 45,656

The project will establish a demonstration training center for home care and other out-of-hospital services to train members of the health professions and related groups in the principles of organization and operation of the out-of-hospital health care programs that serve the long-term patient. It will also collect and exchange information about organized out-of-hospital services, and report on research in programing, administering, and evaluating these services. The training program is designed to offer a variety of training opportunities geared to the total area of home care.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH-20-1-A-63 CH-20-1-B-64 CH-20-1-C-65	Louisiana State University, Baton Rouge, La.; Dr. Clara Tucker.	Oct. 1, 1962 to Sept. 30, 1963... Oct. 1, 1963 to Sept. 30, 1964... Oct. 1, 1964 to Sept. 30, 1965...-	\$18,274 22,518 17,133

This project will demonstrate methods of training homemakers using home economics teachers and will develop curriculums for training homemakers in different kinds of communities. Special training workshops will be established for home economics teachers selected to teach community training classes for homemakers who are adaptable and willing to give homemaking services in families seeking assistance in the care of the aging or the chronically ill. After 3 years of the project, it is estimated that 125 home economics teachers will be trained for leadership responsibilities in community training programs of homemakers, and more than 125 communities will have had opportunity to experience and appraise these programs. Contributions of trained homemakers are hoped to alleviate the personnel shortage in nursing homes and hospitals and in providing medical, nursing, and welfare services.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII-----	CH-28-1-A-65	Montana State Board of Health, Helena, Mont.; Mary E. Soules, M.D.	Oct. 1, 1964 to Sept. 30, 1965... Tentative-----	\$19,585 13,300

The first phase of this project will evaluate the present level of emergency medical services in the State. By appropriate community education, the grantee hopes to stimulate and continue public awareness to the needs in emergency medical services, and to provide training for those persons from a community involved in emergency medical services. Reevaluation of the emergency medical services after proper training has been instituted will determine if the level of service has been raised.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-40-A-64 Supplement A-65	Stanford University, Palo Alto, Calif., Lucille Daniels.	Sept. 1, 1964 to Aug. 31, 1965... Tentative-----	\$34,520 924 34,026 43,547

The purpose of this project is to provide opportunities for students in the basic curriculum and the graduate programs in physical therapy to develop the knowl-

edge and skills at their level of competence to function effectively in a multi-disciplinary out-of-hospital program. Through the cooperative efforts of the grantee and the associate community agencies, the student will be provided provided learning situations in a correlated and integrated didactic and clinical training program. Opportunities for out-of-hospital patient care in conjunction with other medical disciplines will be included in the student's training. Teaching aids and materials will be developed and designed for this area.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH-55-10-A-63	Community Research Associates, Inc., New York, N.Y., Donald B. Glabe.	Sept. 1, 1963, to Aug. 31, 1966, (full funded).	\$268, 122

An inservice training program to produce workers with a combined knowledge of the health problems and social problems of the people they serve. A basic operational pattern for staff development and inservice training will be developed through the combined efforts of key training personnel from the State and county welfare departments. The knowledge and techniques developed will be applied and tested through the public welfare agencies, and a report will be prepared which will deal with the substance and methods of inservice training in health and welfare agencies focusing on the prevention and control of community problems through the use of systematic classificational and rehabilitative procedures.

V. HOME CARE, HOMEMAKER SERVICES, AND NURSING CARE

PHS region	Project No.	Grantee and project director	Period	Amount
I.....	CH-07-1-A-62	Hartford Health Department, Hartford, Conn.; Leonard F. Menczer, D.D.S., M.P.H.	Apr. 15, 1962, to Apr. 14, 1963 (1 year only).	\$2, 875

The project will add a dental component to a community home care program which has been in operation for 6 years. It is designed to provide such dental service as needed commensurate with the patient's physical and emotional tolerance and needs. The project is expected to supply information on dental services in home-care programs which will broaden the base of experience that can be utilized in initiating similar programs elsewhere. PHS support is being used primarily for equipment for the dental care program.

PHS region	Project No.	Grantee and project director	Period	Amount
I.....	CH-23-8-A-63 CII-23-8-B-64	Boston City Hospital, Boston, Mass.; Julius Abramson, M.D.	June 1, 1963, to May 31, 1964... June 1, 1965, to May 31, 1965... Tentative.....	\$34, 344 41, 134 23, 229

The applicant will initiate a home-care program for pregnant cardiac patients to avoid development of congestive heart failure and also reduce hospitalization. Care of such patients at Boston City Hospital has been successful, but long hospitalization and the emotional and financial cost to the patient and her family has often been great. It is hoped that program will establish a pattern which could be followed by other agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
I.....	CH-42-5-A-63	Family Service, Inc., Providence, R.I.; Edward M. Kenly.	July 1, 1963, to Mar. 31, 1965... Tentative.....	\$21, 836 42, 964 48, 688

This project will demonstrate a method of organization for providing home-maker service which will have applicability in sections or localities set off by geographic and other conditions as entities, and which have in combination urban, suburban, and/or semirural characteristics. The demonstration will combine centralized administration and decentralized service units under the sponsorship of a family counseling service which already offers homemaker service as an integral part of its program of casework service.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-32-8-A-63 CH-32-8-B-64	East Orange Health Department, East Orange, N.J.; J. Robert Lackey.	Sept. 1, 1963 to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965... Tentative.....	\$37,680 37,315 37,784

This project will coordinate the efforts of the VNA's of the Oranges and Maplewood, the East Orange General Hospital, and the East Orange Department of Health to provide improved continuity of health services for the chronically ill and aged who are outpatients or discharged hospital patients. It will demonstrate the improvement in health care services that can result from the establishment of a collaborating team made up of members of the staff of a hospital, visiting nurse association, and a health department. Periodic evaluation will be made covering number of persons served, review of services provided, and review of financial statistics to determine cost per patient cared for.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-7-A-62 CH-34-7-B-63 CH-34-7-C-64	Rip Van Winkle Foundation, Hudson, N.Y.; Caldwell Blakeman Esselstyn, M.D.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$60,000 60,000 60,000

The purpose of this project is to establish a comprehensive program to meet the out-of-hospital needs of the chronically ill and aged in a rural community which has a high proportion of chronically ill and aged persons. It is expected this project will demonstrate how a countywide organization, by mobilizing and coordinating all resources, can best approach the problem of providing continuity of service and a direct comprehensive health care program in a rural area. Data will be provided as to the kinds and numbers of services required in such a program and costs of services.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-21-A-63 CH-34-21-B-64 CH-34-21-C-65	Visiting Nurse Service of New York, New York, N.Y.; Mrs. Ione Carey.	Dec. 1, 1962, to Feb. 29, 1964... Mar. 1, 1964, to Feb. 28, 1965... Mar. 1, 1965, to Feb. 28, 1966...	\$161,404 180,012 130,000

This project will demonstrate the feasibility of providing a visiting home aid service to the chronically ill and aged in conjunction with the visiting nurse services. The "home aid" as used in this project is a person oriented toward work in homes with chronically ill or aged patients when no family member is available to care for the home and the patient's personal needs. A nurse supervises the aid and evaluates the patient's and the family's need for services. The sponsor plans to determine the extent of the need for home aid service in the Visiting Nurse Service of New York caseload of the chronically ill and aged in Queens; the types of workers required to meet the needs of the patients and families served and the possibility for recruiting these workers; and the cost of home aid services. Also, the sponsor will determine the effect on the nursing service by addition of the aid program.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-22-A-63 CH-34-22-B-64	Visiting Nurse Association of Brooklyn, Inc.; Patricia Hughes.	Mar. 1, 1963, to May 31, 1964. June 1, 1964, to May 31, 1965. Tentative-----	\$43,045 42,822 39,854

This project will demonstrate the effectiveness of adding home visiting aids to the health team of the VNA. They will work as members of the nursing team and be supervised by the professional staff members and the project director, assisting with personal care and doing simple household tasks. It is expected to determine the feasibility of adding such a group to the VNA team as well as to determine the best method for training them.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-29-A-63 CH-34-29-B-64	District Nursing Association of Northern Westchester County, Mount Kisco, N.Y.; Sybil P. Bellos.	Sept. 1, 1963, to Aug. 31, 1964. Sept. 1, 1964, to Aug. 31, 1965. Tentative-----	\$46,000 44,840 27,130

This project will develop a corps of nonprofessional workers to be known as health aids who will assist in the care of chronically ill patients in their homes. It will demonstrate the distinctive roles and the types of professional activity required of the professional social worker and the public health nurse in initiating and maintaining a quality health aid service, and ascertain which personal services and housekeeping duties can be performed by a trained health aid in the person's home under direct supervision of the project PHN. It will also make a study of the cost of such a service in a highly rural community. The project will utilize the existing social service department of Northern Westchester Hospital, the nursing and consultant services of the Westchester County Department of Health, and will be an integrated part of the DNA of Northern Westchester.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-33-A-64 CH-34-33-B-65	Council of Social Agencies of Rochester & Monroe County, Inc., Rochester, N.Y.; Grace B. Chilianan, R.N.	Mar. 1, 1964, to Feb. 28, 1965. Mar. 1, 1965, to Feb. 28, 1966. Tentative-----	\$20,005 21,310 22,533

The purpose of this project is to demonstrate the effectiveness of a minimal cost foster family care program for a select group of aged and infirm persons for whom this type of care is appropriate. The value of such a program should result in (a) maintenance of independence for a longer period of time, (b) prevention of premature or inappropriate placement in other care settings, and (c) prevention of premature mental and physical deterioration.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-48-A-64 Supplement A-65.	St. Luke's Hospital, New York, N.Y.; Dr. Paul R. Torrens.	Sept. 1, 1964, to Aug. 31, 1965. Tentative-----	{ \$46,227 5,730 48,714 50,670

Morningside Gardens is a group of middle-income cooperative apartments in New York City. The purposes of this project are to determine the need for and utilization of various health and health-allied services among the residents of such a housing project, to determine the ability of this group to meet the needs for these

services by utilizing volunteer workers drawn from the group itself, and to determine the feasibility of establishing a prepaid, self-supporting insurance plan to provide those services which cannot be provided by the volunteer workers. Periodic evaluations will be made.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-1-A-63 CH-40-1-B-64	Pennsylvania Department of Health, Harrisburg, Pa.; Miss Margaret K. Murphy.	Nov. 1, 1963, to Oct. 31, 1964--- Nov. 1, 1964 to Oct. 31, 1965--- Tentative-----	\$12,055 6,719 6,461

The purpose of this project is to prove that the addition of licensed practical nurses to the nursing staff for home nursing care is economical and permits better care of more people. It is the opinion of the sponsor that many of the services required by chronically ill persons could be given as well by practical nurses, and this project will make job studies and judgmental analyses of nurse functions in new areas of service in order to determine the level of preparation necessary for the various aspects of care, and to determine whether those tasks which do not require public health or professional nursing competence can be grouped so as to make such differential assignment feasible and safe. Quantitative and qualitative analyses will be made of the effect of using such practical nurses.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-14-A-62 CH-40-14-B-63 CH-40-14-C-64	Phoenixville Community Nursing Service, Phoenixville, Pa.; Miss Ida Mae Siegfried.	July 1, 1962, to June 30, 1963--- July 1, 1963, to June 30, 1964--- July 1, 1964, to June 30, 1965---	\$12,790 10,182 7,800

The sponsor is making a 3-year study of the feasibility of providing physical rehabilitation services at home for the chronically ill and aged. It is expected to demonstrate that a visiting nurse in a small community can provide good physical rehabilitation care in the home and to document the value of home rehabilitation with statistics based on this program. The experience gained should be of value as a guide for VNA's elsewhere.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-21-A-62 CH-40-21-B-63	Visiting Nurse Association of Allegheny County, Inc., Pittsburgh, Pa.; Alice K. de Benneville, R.N., M.P.H., Betty Jane McWilliams, Ph. D.	May 15, 1962, to May 14, 1963-- May 15, 1963, to May 14, 1964 (2 years only).	\$24,960 23,905

This project will demonstrate the extension of services of the VNA to include services to patients with special defects, particularly those resulting from cerebral accident, spasticity, and other neurological center speech defects. These services are provided in the home by a full-time speech clinician who guides public health nurses in providing supportive services to patients. Staff of the University of Pittsburgh Speech Department are assisting in developing and evaluating the program. The results of the demonstration could make a worthwhile contribution to the total rehabilitation plan for the patient and could also be beneficial in improving the emotional health of the patient and his family.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-52-A-64	Jefferson Medical College and Medical Center, Philadelphia, Pa.; Joseph F. Rodgers, M.D.	June 1, 1964, to May 31, 1965--- Tentative-----	\$44,493 44,493 44,493

A home care program will be established to provide coordinated medical and nursing care to chronically ill patients who are essentially homebound. The program will be hospital based; all activities, including physicians' services, laboratory services, X-rays, medications, etc., will be coordinated by the grantee. Paramedical services will be purchased from Community Nursing Service of Philadelphia and other existing agencies in the city. Coordination of services will provide needed medical services to a segment of the population often neglected, and will also greatly improve the efficiency of bed utilization by decreasing the stay and preventing unnecessary hospitalization.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH-22-4-A-63	Talbot County Health Department, Easton, Md.; Louis S. Welty, M.D., M.P.H.	Feb. 1, 1963, to Apr. 30, 1964, (project canceled after 1st year of operation).	\$23, 444

A project to demonstrate the value of using public health nurses to assist in discharge-planning for patients released from the Memorial Hospital in Easton. It will measure the effect of the planning on length-of-stay and readmission rate of those patients who were admitted for hospitalization at State expense. Because the area is one with limited financial resources and facilities, it is felt that the result of the study will be of benefit to other areas with similar characteristics.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH-35-8-A-63	Durham County Health Department, Durham, N.C.; Dr. O. L. Ader.	July 1, 1963, to June 30, 1965 (full funded).	\$21, 630

The Department has designed a program to determine the value of home follow-up care on patients with congestive heart failure. In this program the services of a nurse are utilized in bridging the gap between the physician and the dietician in established medical facilities and the patient and his family at home. The department plans to determine whether better control of congestive heart failure can be obtained by followup home care of this type, whether the frequency and length of hospitalization for recurrent congestive heart failure can be decreased, and what the comparison of total money spent for the care of congestive heart failure in the control and home followup groups is.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH-49-1-A-62 CH-49-1-B-63 CH-49-1-C-64	Fairfax County Health Department, Fairfax, Va.; Harold Kennedy, M.D., M.P.H.	Aug. 1, 1962, to July 31, 1963... Aug. 1, 1963, to July 31, 1964... Aug. 1, 1964, to July 31, 1965...	\$33, 434 45, 502 37, 536

The objective of the project is to establish a coordinated home-care program and to demonstrate the value of this type of service for the medical, social, and psychological adjustment of the patient and the family to problems of the chronically ill and aged patient in the home. The local health department will coordinate the activities of a number of other community resources for delivery of a wide variety of home-care services. It is expected to add homemaker services to the program.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH-52-2-A-63 CH-52-2-B-64.... CH-52-2-C-65	Family Service Association, Morgantown, W. Va.; Mrs. Leonard Sizer.	Jan. 1, 1963, to Dec. 31, 1963... Jan. 1, 1964, to Dec. 31, 1964... Jan. 1, 1965, to Dec. 31, 1965...	\$38, 904 47, 250 54, 275

The project will provide, for the first time in Monongalia County, a countywide visiting homemaker service which will be aimed primarily at the chronically ill and aged. Its purpose is to enable such persons to remain in their own homes, if possible, or to reduce their length of stay in hospitals. It will supplement the work of the bedside nursing program of the county health department, and will develop a continuing demonstration and evaluation program to test the efficiency of such a service.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-52-4-A-63 CH-52-4-B-64 CH-52-4-C-65	Children & Family Service Association, Inc.; Manuel J. Viola.	Mar. 1, 1963, to Feb. 29, 1964-- Mar. 1, 1964, to Feb. 28, 1965-- Mar. 1, 1965, to Feb. 28, 1966--	\$20,972 23,112 21,808

A project to determine whether home care for the chronically ill and aged, through homemaker services, will prevent unnecessary hospitalization for this group, and whether the homemaker can provide basic services; or, will it be necessary to use other services such as meals-on-wheels, volunteers, and other community resources. The project will be carried out in cooperation with the Visiting Nurses Association of Ohio County, who will provide a physical therapist as well as visiting nurses.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-52-5-A-63 CH-52-5-B-64	Visiting Nurse Association of Ohio County, Inc., Wheeling, W. Va.; Regina C. Griffith, R.N.	Aug. 1, 1963, to July 31, 1964--- Aug. 1, 1964, to July 31, 1965--- Tentative-----	\$19,197 21,561 19,521

This project will provide support for the Visiting Nurse Association, which is working in conjunction with the Children and Family Service Association and the local health department in providing homemaker services. The need for such services will be defined, and an analysis of the homemaker's job in relation to the agency best fitted to administer the service will be made. Emphasis will be placed on the utilization and evaluation of individual methods of referral, and better utilization of health and welfare resources. The sponsor will also study and evaluate the contribution of a physical therapist and licensed practical nurse to the public health nursing program.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-01-2-A-62 CH-01-2-B-63 CH-01-2-C-64	Visiting Nurse Association, Birmingham, Ala., Mrs. Helen Lloyd.	July 1, 1962, to June 30, 1963--- July 1, 1963, to June 30, 1964--- July 1, 1964, to June 30, 1965---	\$35,349 37,313 37,311

The association will study the effect of communitywide homemaker activities in health-care programs for the chronically ill and aged in Jefferson County. The sponsor plans to experiment in the use of male homemakers for certain types of situations; determine the cost of providing such services; and identify the needs of the chronically ill and aged, and study how many of these can be met through homemaker services. Homemakers age given training prior to assignment to give services in the home. A variety of community resources representing several professional disciplines will be used in teaching the homemaker course. It is expected a teacher's guide will be developed. Other community participation includes the selection and appointment of an advisory committee from representative community agencies supporting the project, and possibly using the services.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-19-A-65	Community Chest & Council of the Cincinnati Area, Cincinnati, Ohio; Mrs. Mary H. Little.	Jan. 1, 1965, to Dec. 31, 1965--- Tentative-----	\$42,850 70,300 67,200

This project is a demonstration of home-aid service for chronically ill patients and feeble, aged persons in a large metropolitan area covering five counties in two States. The main objectives are to learn how to give such service in a large area, to delineate more clearly the characteristics of such a service as distinguished from traditional homemaker services, to learn how to relate such service to a protective program for older people, and to learn how best to correlate the service with a home medical care program. One of the aims of the project is the determination of auspices under which the service can best be given.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-18-1-A-63 CH-18-1-B-64	University of Kansas Medical School, Kansas City, Kans.; Charles E. Lewis, M.D.	July 1, 1963, to June 30, 1964--- July 1, 1964, to June 30, 1965--- Tentative-----	\$58,227 61,019 63,304

This project will establish a combination service and training program in home care and community health, coordinating services of the sponsor, local health departments, and the Visiting Nurse Association of Kansas City. It will provide services for certain indigent medical patients in the community, through various community agencies. Student nurses and other students will rotate through this program in addition to various other community health projects. The program will provide for teaching and demonstration as well as service, and will demonstrate the feasibility of such integrated care in a metropolitan area, and the need for coordinated effort by both official and voluntary health agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-18-2-A-64 CH-18-2-B-65	Cloud County Health Department, Concordia, Kans.; Elta M. Kennedy, R.N.	Jan. 1, 1964, to Dec. 31, 1964--- Jan. 1, 1965, to Dec. 31, 1965--- Tentative-----	\$13,844 12,548 16,510

The Cloud County Health Department will determine the need for, demonstrate, and ascertain the additional cost of providing for citizens of all ages and at all economic levels, nursing care of the sick at home. This particular type of rural nursing care in the home has not been successfully demonstrated in this county, and in some surrounding States, and the achievement of the objectives should contribute to the extension of public health and visiting nursing in rural communities.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-27-17-A-63 CH-27-17-B-64	Department of Health and Hospitals, St. Louis, Mo.; Bernard T. Garfinkle, M.D.	July 1, 1963, to June 30, 1964--- July 1, 1964, to June 30, 1965--- Tentative-----	\$17,350 17,000 16,850

This program will be directed toward the control of recurrences of congestive heart failure and reduction of multiple hospital admissions for this group of patients by the use of paramedical personnel in an organized followup program. The program will incorporate regular home visits by visiting nurses, diet counseling for the patients, and medical social worker consultation for correction of socio-economic problems. It is hoped that such services will lessen the problems commonly arising in congestive heart failure patients, which tend to bring on recur-

rences, and regular visits by a nurse will detect early changes in the patient's condition which warrant outpatient therapy and thereby prevent rehospitalization.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-27-23-A-64	Catholic Charities of St. Louis, St. Louis, Mo.; Rev. Robert P. Slattery, M.S.W., A.C.S.W.	Sept. 1, 1964, to Aug. 31, 1965... Tentative-----	\$104,480 146,335 150,580

This project will develop a method of providing comprehensive home care services to meet the total physical, social, and emotional needs of aged and/or chronically ill persons within the scope (including the cost factor) of individual and community resources. This would be an organizational model which can be duplicated in other communities or parts of this community. It will identify services currently available, identify patient characteristics which enhance or detract from a person's acceptance or rejection of comprehensive home care services, and establish a cost accounting system to determine the unit costs of providing home care services. It will also utilize the training potential in the project to develop course outline, curriculum, and training objectives for training of paramedical personnel, case aids, and neighborhood volunteers.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-36-1-A-62 CH-36-1-B-63 CH-36-1-C-64	Fargo City Health Department, Fargo, N. Dak.; D. H. Lawrence, M.D.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$6,953 7,418 7,164

A project to extend official public health nursing services to provide home nursing care for the chronically ill and aged, and show the value of therapeutic nursing services as a part of a health department nursing program. Also, it is to provide clinical experience for nursing students from the college of nursing. It is expected that such a demonstration will be of value to other communities in North Dakota and in neighboring States in planning for home nursing care in rural areas.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH-38-4-A-62 CH-38-4-B-63 CH-38-4-C-64	University of Oklahoma, Norman, Okla.; Charles McDaniel.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$21,470 18,650 16,156

A project to demonstrate and evaluate a method of establishing homemaker services in small communities in Oklahoma, to increase the rate of development of homemaker services, especially in medium-sized and smaller communities, and to develop a method of insuring an increasing supply of persons available to provide such services in a community. Professional home economists are to receive a 2-week training course to prepare them to teach a homemaker training course within their own community. Within each participating community, an interagency committee is to be formed to promote and sponsor the training programs and homemaker services. The project staff will provide local training programs with educational and promotional materials.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH-46-1-A-62 CH-46-1-B-63 CH-46-1-C-64	Santa Rosa Medical Center, San Antonio, Tex.; John A. Bradley, Ph. D.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to Aug. 31, 1964...	\$70,800 63,200 8,314

The objectives of the project are to develop a coordinated home care program by extending hospital services to the home and coordinating these with services in the community. Through this program, facilities available will be extended to

out-of-hospital patients who are within the upper age group and are suffering from chronic conditions. The study will provide valuable experiences for the establishment of other programs within the region where no program is available.

PHS region	Project No.	Grantee and project director	Period	Amount
VII.....	CH-46-2-A-63 CH-46-2-B-64	Fort Worth Society for Crippled Children & Adults, Inc., Fort Worth, Tex., David Hoehn, M.D.	June 1, 1963, to May 31, 1964... June 1, 1964, to May 31, 1965... Tentative.....	\$55,161 50,495 51,088

This project will demonstrate improved home rehabilitation services for the chronically ill through the extension of the sponsor's existing rehabilitation services, and in conjunction with the Division of Public Health Nursing, Fort Worth and Tarrant County Health Departments. The major objectives will be (1) treatment of people in their homes on a communitywide basis, (2) educational programs within the hospital and the medical society, and (3) community education of the value of rehabilitation services. Project evaluation will consist of a comparative analysis of the individual gains and related significance as observed and reported by the referral source, the family of the patient, and the rehabilitation team.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH-06-1-A-62 CH-06-1-B-63 CH-06-1-C-64	Visiting Nurse Association of the Denver Area, Inc.; Denver, Colo., Margaret D. Lewis.	June 1, 1962, to May 31, 1963... June 1, 1963, to May 31, 1964... June 1, 1964, to May 31, 1965...	\$33,418 44,108 49,757

This project is to determine the feasibility of using home aids to provide services in the home to patients requiring some type of nursing care, as opposed to the traditional homemaker services. Supervision of the nursing care rests with the nursing staff. The home aids are to be oriented and will receive in-service education by the home aid director in cooperation with the visiting nurse service. The project is designed to document the steps in the organization and administration of the service, establish criteria for the determination of staffing patterns, study the costs to the community, and study its effect as a demonstration in the development of similar services on a statewide basis. A careful cost accounting will be maintained so that a realistic basis for cost computation can be achieved.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH-06-3-A-62 CH-06-3-B-63 CH-06-3-C-64	Colorado State Department of Public Health, Denver, Colo., Robert A. Downs, D.D.S.	Aug. 15, 1962, to Aug. 14, 1963... Aug. 15, 1963, to Aug. 14, 1964... Aug. 15, 1964, to Aug. 14, 1965...	\$12,160 10,600 7,956

A study to determine the contributions a dental hygienist can make to improve the dental health status of the chronically ill and handicapped individuals who are confined to nursing homes or are homebound. The hygienist is to develop a program of casefinding and screen and refer those needing the services of a dentist to appropriate dental resources. Further, the chronically ill and handicapped are to be taught how to maintain adequate oral hygiene, and instructions in proper oral hygiene procedures are to be given to those caring for patients in the home.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH-47-1-A-64	Salt Lake Community Nursing Service, Salt Lake City, Utah; Maxine A. Thomas.	Apr. 1, 1964, to Mar. 31, 1965... Tentative.....	\$27,346 26,890 18,000

This project will organize and administer a visiting homemaker service as a division of the Salt Lake Community Nursing Service and establish a pattern for the development of similar service in other communities in Utah. The aim is to assist the chronically ill and aged in the community to attain independent living in a home environment. Training courses have been prepared for certified home assistants, and emphasis will be placed on developing competency in the homemaker to teach clients or their families the activities of daily living and home management.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-7-A-62	Homemaker Service of Pasadena Area, Inc., Pasadena, Calif.; Mrs. Cerna S. Hirsch, Mrs. Wilma K. Jordan (3d year).	July 1, 1962, to June 30, 1963----	\$49,643
	CH-05-7-B-63		July 1, 1963, to June 30, 1964----	33,096
	CH-05-7-C-64		July 1, 1964, to June 30, 1965----	16,547

This project is designed to help determine the nature of and extent to which a homemaker service can play a supporting role in the care and treatment of chronically ill or aged patients outside of the hospital on a professionally adequate but economical basis. The project is to be conducted in the Pasadena area. It will more accurately identify the nature and extent of the need for homemaker services, establish and maintain valid methods of securing reliable program service statistics, establish and maintain a cost accounting system that will provide accurate cost factors, validate methods of organization and administration of homemaker service in a large metropolitan area, and establish criteria for the referral and acceptance of patients for homemaker service.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-10-A-62	Contra Costa County Health Department, Martinez, Calif.; Joseph F. Whiting, Ph. D.	Nov. 15, 1962, to Nov. 14, 1963--	\$59,375
	CH-05-10-B-63		Nov. 15, 1963, to Feb. 28, 1965 (2 years only).	80,346

Through this study the health department expects to determine whether a new method of providing home health services to the chronically ill and aged and their families (by use of a new type of home visitor and community worker) meets their personal health needs better and more economically than current practices. A further objective is to identify the kinds of skills needed to provide these services, and to begin work with the institutions of higher learning to development educational preparation with attention to costs. A demonstration is to be set up and records are to be kept to enable comparisons between the new services, functions, costs, and outcome and the services traditionally given. Attention is also to be directed to the organization for rendering these services.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-33-A-64	Family Service Association, San Diego, Calif.; Mrs. Eula Hamman.	July 1, 1964, to June 30, 1965---	\$53,640
			Tentative-----	{ 52,440 47,130

This demonstration will show how a selected group of incapacitated adults can be cared for effectively in their homes by a homemaker service with a public health nurse added. The objectives are to develop a new pattern of collaboration between a homemaker agency and a visiting nurse association to meet the changing needs of chronically ill and aged individuals who cannot remain in their homes without some community intervention, to identify individuals who can use this service effectively, and to evaluate the program's effectiveness in meeting the needs of incapacitated adults and referral agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-42-A-64	San Francisco Homemaker Service, San Francisco, Calif.; Miss Brahna Trager.	Aug. 15, 1964, to Sept. 14, 1965-- Tentative-----	\$87,855 153,010 173,925

This demonstration of a health-centered program which will provide in-home services to the chronically ill and aged of the community will add social workers, public health nurses, homemakers, home health aids, and attendants to the staff of three health centers in the community and will provide orientation, training, and supervision directed toward the development of counseling and referral, health maintenance, supervision of in-home plans utilizing homemakers and home health aids, maximum utilization of community resources and coordination of appropriate services. The use of the health center as the base for these services is intended to demonstrate the function of the health department in a chronic disease program. Although volume statistics will be available after the third year for evaluation of the project, of particular concern will be how certain inter-related variables influence success or failure in satisfactorily maintaining the patient at home.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-13-1-A-62 CH-13-1-B-63	St. Francis Hospital, Honolulu, Hawaii; Sister M. Aileen, R.N.	Apr. 1, 1962, to Mar. 31, 1963-- Apr. 1, 1963, to Dec. 31, 1964 (2 years only).	\$51,382 46,178

This project establishes a communitywide hospital-based program through which team health services and intermediate equipment are supplied to the chronically ill and aging regardless of their economic level. One hospital, with agreement of the other two, operates a coordinated program for all three hospitals. The study proposes to determine the feasibility of a program of continuity of care from hospitals to homes and homes to hospitals within a designated geographical area in Honolulu. Out-of-hospital needs of patients in terms of staff, equipment, and facilities will be studied, with demonstration of methods for meeting these needs. Further, opportunities will be explored for provision of educational experiences for patients and their families, interested community groups, and medical and paramedical personnel.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-30-1-A-62 CH-30-1-B-63 CH-30-1-C-64	Nevada Tuberculosis and Health Association, Reno, Nev.; Mrs. Elaine Walbroek.	July 1, 1962, to June 30, 1963-- July 1, 1963, to June 30, 1964-- July 1, 1964, to Dec. 31, 1965--	\$34,302 66,149 68,122

The sponsor will establish a homemaker service in a rural, sparsely populated area where there are almost no medical or social services. The project is to demonstrate that multicounty, multiagency cooperation can make possible the operation of such a service where limited facilities and resources in any one of the counties would prohibit its initiation. Further, it will provide information as to how best to develop homemaker services in a sparsely populated area and one with different cultural groups, as well as the feasibility of the establishment of such services in rural areas.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-39-2-A-63 CH-39-2-B-64 CH-39-2-C-65	Harvey E. Rinehart Memorial Hospital, Wheeler, Oreg.; Mrs. Genevieve W. Smith, R.N.	Mar. 1, 1963, to Feb. 29, 1964-- Mar. 1, 1964, to Feb. 28, 1965-- Mar. 1, 1965, to Feb. 28, 1966--	\$19,442 19,448 22,395

The project will provide visiting nurse services to residents within a 20-mile radius of the hospital using the hospital nursing staff. Patients will be referred by the medical staff, and home visits will carry out treatment as ordered by the doctor under the supervision of a nurse coordinator. Evaluation will be based on demands and use for service, checking expenses against income, and consideration of staffing problems.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-39-3-A-63 CH-39-3-B-64 CH-39-3-C-65	Eugene-Springfield Area Homemaker Demonstration & Research Project, Inc., Eugene, Oreg.; Donald L. England, M.D.	Feb. 1, 1963 to Jan. 3, 1964----- Feb. 1, 1964, to Jan. 31, 1965--- Feb. 1, 1965, to Jan. 31, 1966----	\$27,500 30,250 29,680

A homemaker demonstration and research project for the Eugene-Springfield area, one with limited resources, for home care service which will research the cost of not providing homemaker services to the chronically ill and aged. The results of the research will be made available to other communities which may wish to establish or modify homemaker services.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-51-1-A-63 CH-51-1-B-64 CH-51-1-C-65	King County Hospital System, Seattle, Wash.; K. K. Sherwood, M.D., Kenneth N. Anderson, M.D.	Dec. 1, 1962, to Nov. 30, 1963--- Dec. 1, 1963, to Nov. 30, 1964--- Dec. 1, 1964 to Nov 30, 1965-----	\$56,879 62,200 62,200

This project combines a rehabilitation team with an established home care program. It is known that the long hospitalization and accompanying cost for rehabilitation therapy prevents many patients from being rehabilitated. If such therapy could be given in the home, many more patients could receive the benefit of rehabilitation therapy. Studies are needed to find better and more economical methods of meeting this need. The sponsor will conduct a controlled study to demonstrate that many patients could be discharged to their homes much earlier by receiving physical therapy treatment, plus necessary medical and nursing care, in the home; when sufficiently recovered, they will be transferred to the outpatient physical therapy department of the hospital for continued care. It is hoped to prove that the methods developed will result in the same degree of recovery of the patient, as compared to the hospitalized patient, at much less cost.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-51-4-A-63 CH-51-4-B-64	King County Hospital System, Seattle, Wash.; Richard A. Warren.	Aug. 1, 1963, to July 31, 1964--- Aug. 1, 1964, to July 31, 1965 (2 years only).	\$46,834 95,558

Through this program dietetic therapy will be extended into the home under the home care for the aged plan. This project results from the knowledge of past experience that many patients on the hospital extension service do not receive adequate nutritional therapy. The program will include dietetic instruction and preparation and delivery of therapeutic diets prescribed by doctors and planned by dietitians.

PHS region	Project No.	Grantee and project director	Period	Award
National.	CH-55-5-A-62 CH-55-5-B-63 Supplement B-65	National Council on Aging, New York, N.Y.; Mary F. Champlin.	Aug. 1, 1962. to July 31, 1963--- Aug. 1, 1963, to Dec. 31, 1964 (2 years only).	\$39,343 26,626 7,100

The project proposes to make a study of the services now offered by current portable meals programs, how they are operated, the inadequacies, and the difficulties of operating such a program, to enlist the help of professional and technical persons in solving the practical problems of furnishing portable meals, and to recommend guidelines for portable meals programs. It is expected the study will provide information which will be useful to community health and welfare agencies and other organizations in planning and coordinating out-of-hospital services for the chronically ill and aged.

VI. EXTENSION AND IMPROVEMENT OF FACILITIES AND SERVICES FOR CHRONICALLY ILL AND AGED, INCLUDING NURSING HOMES

PHS region	Project No.	Grantee and project director	Period	Amount
I.....	CH-23-12-A-63 CH-23-12-B-64	Florence Heller Graduate School, Waltham, Mass.; Howard E. Freeman.	June 1, 1963, to May 31, 1964... June 1, 1964, to May 31, 1965... Tentative.....	\$118,140 132,430 112,846

This project provides for a study of the role of the nursing home in the provision of care for the aged. It will seek to describe the post-hospital experiences of patients discharged to nursing homes, and compare these experiences with those of patients who return to their homes or other community settings. It will (1) provide a description of current nursing home care, (2) suggest ways to modify current practices in the care of nursing home patients, and (3) formulate plans for more effective and efficient ways of utilizing nursing homes within the medical care system.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH-34-47-A-64	United Hospital Fund of New York, New York, N.Y.; Helen M. Gossett.	June 1, 1964, to May 31, 1965... Tentative.....	\$53,230 { 58,130 58,130

The main objectives of this project are to assess the types of social problems of chronically ill and elderly patients in nursing homes, assess the extent of service needed, and provide supportive services to residents of these homes and their families. Casework in the nursing homes will be provided by social workers under the supervision of the project director, and continuity of help to patients transferred from hospitals will also be given, thus effecting speedier hospital discharges.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH-40-47-A-64	Visiting Nurse Association of Allegheny County, Pittsburgh, Pa.; Mrs. Alice K. de Benneville.	Apr. 1, 1964, to Mar. 31, 1965... Tentative.....	\$30,900 { 30,325 23,230

Public health nurses find that for some stroke patients care at home is no longer providing the necessary motivation for self-help and that a need exists to develop new ways of helping them retain physical gains and participate again in community life. Under the direction of the VNA and an association of neighborhood houses, a group work program for stroke patients and their families will be established in four to five settlement houses to demonstrate a method for contributing to the rehabilitation of stroke patients through a coordinated approach.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH-09-10-A-65	District of Columbia Department of Public Health, Washington, D.C.; Murray Grant, M.D.	Jan. 1, 1965, to Dec. 31, 1965... Tentative.....	\$116,028 { 85,606 62,574

This project is designed to improve the standards of nursing homes and patient care in nursing homes in the city. It will offer multidisciplinary services to the patients of nursing homes, introducing these services through a screening of the patient and of the home. Training of nursing home personnel will be provided. Knowledge of and utilization of community resources available to nursing homes will be promoted.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-22-9-A-64 CH-22-9-B-65	Baltimore City Hospitals, Baltimore, Md.; H. Glenn Waring, D.D.S.	Dec. 1, 1963, to Nov. 30, 1964... Dec. 1, 1964, to Nov. 30, 1965... Tentative.....	\$77,316 59,889 46,922

This project will develop appropriate administrative patterns which will make the provision of dental care an integrated part of the program of the chronically ill patients in Maryland. It will provide dental services to the chronically ill and aged in the Baltimore City hospitals, nursing home system, and private foster homes, by the expansion of present hospital dental service through the extension of out-of-hospital services.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-20-A-64	Toledo District Board of Health, Toledo, Ohio; Gladys M. Spear.	Aug. 1, 1964, to July 31, 1965... Tentative.....	\$17,399 16,546 16,567

This is a demonstration of improvement of the management of dietary service in nursing homes through shared professional service and selective training of food service personnel. The project is designed to acquaint administrators of nursing homes and related facilities with the regular, part-time assistance of professional dietitians and with the full-time vocationally trained food service supervisors. Regular dietary consultation will be given to selected nursing homes and related long-term care facilities on a voluntary basis. After a period of demonstration of professional assistance, the consultant employed will recruit, orient and assist with the placement of professional dietitians in those facilities which wish to employ them. Administrators will be requested to submit evaluation and progress reports periodically which will give the consultant an opportunity to appraise the long range effects of the demonstration as well as the attitude of the administrator toward providing adequate food service for patients.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-53-1-A-62	Milwaukee Health Department, Milwaukee, Wis.; Gertrude Mulaney.	June 18, 1962, to May 1, 1963 (1 year only).	\$22,184

This project is directed to the quantitative measurement of the amount of nursing service needed in nursing homes and subjective evaluation of the quality of nursing care provided. The study entails identification of all nursing procedures utilized in the direct care of patients and a recording of the units of time consumed in carrying out each procedure. In addition, determination is to be made as to the quality of patient care rendered and an evaluation made of nursing home personnel best capable of carrying out each procedure.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-18-3-A-65	Kansas State Department of Health, Topeka, Kans.; Conie C. Foote.	Award not made as of Dec. 31, 1964.	\$24,517 27,389 16,092

In this project professionally qualified dietitians will develop a training program for food service personnel in adult care homes and demonstrate to administrators of such homes how trained food service supervisors and professional dietary consultation service can help them with food service management. Locally recruited dietitians will be employed in the homes under the supervision of project staff. Training programs to be developed in cooperation with the State vocational and adult education programs will be continued beyond the project.

PHS region	Project No.	Grantee and project director	Period	Amount
VII.....	CH-38-3-A-62 CH-38-3-B-63 CH-38-3-C-64	Oklahoma State Department of Health, Oklahoma City, Okla.; Forest R. Brown, M.D.	Aug. 1, 1962, to July 31, 1963... Aug. 1, 1963, to July 31, 1964... Aug. 1, 1964, to July 31, 1965...	\$31,396 54,675 51,989

This project is concerned with the development of a training program which will equip nursing homes to meet the nutritional, occupational, and social needs of the patient. It also proposes to develop training materials such as food service manuals, guidelines on the use of volunteers, and a handbook for volunteers which could be used by other nursing homes. Demonstrations of the training program will be made to nursing home personnel, to local health departments, and to the community at large.

PHS region	Project No.	Grantee and project director	Period	Amount
VII.....	CH-38-9-A-65	University of Oklahoma, Oklahoma City, Okla.; Dr. Claude M. Bloss, Jr.	Oct. 1, 1964 to Sept. 30, 1965... Tentative.....	\$52,653 { 51,554 51,554

The principal objective of this project is to contribute to the overall improvement of care in nursing homes in Oklahoma through the provision of physical therapy services to patients in such homes. It will establish and test a method of providing physical therapy services in 149 Oklahoma nursing homes, demonstrate to nursing home administrators and the consumer public the value of adding these services, and encourage practicing physical therapists to provide services to the geriatric patient on a part-time basis.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH-06-5-A-64	Colorado State Department of Public Health, Denver, Colo.; John Lichty, M.D.	Mar. 1, 1964 to Mar. 31, 1965... Tentative.....	\$148,947 { 151,634 162,546

Because of the large increase in the number of chronically ill, aged, and physically disabled who require rehabilitation services but do not need hospitalization, this project will attempt to find satisfactory means to meet this need as economically as possible. Intensive rehabilitation services will be provided to two groups of patients—one in a home or nursing home, the other in a clinic setting, and the results achieved in the two settings compared. Evaluation will include a comparison of initial prognosis with final level of rehabilitation reached, and comparison of the two treatment groups in order to determine which is the more effective.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH-06-6-A-64	Colorado State Department of Public Health, Denver, Colo.; John A. Lichty, M.D.	July 1, 1964 to June 30, 1965 (1 year only).	\$12,500

The grantee will produce a 20-minute color training film concerning food service in nursing homes which will fill a gap in materials now available for training courses for all types of nursing home personnel. The purpose of the film will be to identify to nursing home personnel what good food service is, what it can mean to patients, and how such service can be obtained. A contract will be awarded to a commercial firm with professional consultation provided by the grantee.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII-----	CH-14-3-A-64	Idaho Department of Health, Boise, Idaho; Richard D. Adams.	July 1, 1964, to June 30, 1965... Tentative-----	\$27,876 15,745 16,200

The department of health will demonstrate in nursing homes, boarding homes, and related facilities the effectiveness of comprehensive fire and accident prevention programs for reducing hazards and improving patient morale and sense of security. Two technically qualified fire and accident consultants will provide consultation and educational services. Each facility will be surveyed to evaluate fire safety as applicable to current regulations, and after the initial survey will be revisited to assist in developing fire evacuation plans, etc. The program will be evaluated on the basis of requests for consultation and educational programs to be conducted.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-51-3-A-63 CH-51-3-B-64	Washington Dental Service, Seattle, Wash.; Howard B. Henderson, D.M.D.	Apr. 1, 1963, to Mar. 31, 1964... Apr. 1, 1964, to Mar. 31, 1965 (2 years only).	\$50,036 39,161

This project will conduct an analysis of needs, utilization and cost of dental services for nursing home residents, to be rendered in and out of nursing homes by private practitioners through the administration of a dental service corporation. Administrative and clinical policies, standards and procedures will be developed and evaluated and the actual costs for the demonstration group and estimated costs for the nursing home population of the State will be determined.

VII. CENTRAL REFERRAL AND INFORMATION SERVICES

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-23-4-A-62	Harvard University School of Public Health, Boston, Mass., Leonid S. Snegireff, M.D.	Aug. 1, 1962, to July 31, 1965, (full funded).	\$51,957

This project transferred at the end of the first year to:

PHS region	Project No.	Grantee and project director	Period	Amount
	CH-23-4-B-64 CH-23-4-C-65	Brandeis University, Waltham, Mass., Howard E. Freeman, Ph. D.	Aug. 1, 1963, to July 31, 1964... Aug. 1, 1964, to July 31, 1965...	\$16,330 21,390

A project to set up and test a procedure for coding case records of selected agencies providing services for the chronically ill. Data will be analyzed for the purpose of studying and evaluating these services. Detailed information will be obtained on the caseload, areas of unmet need, and problems of interagency relationships. Factors will be explored affecting utilization of community services; service methods and practices will be evaluated in terms of their meeting

needs of the chronically ill and aging. It is also hoped to identify additional areas of needed research relating to community services for the chronically ill, and to utilize the study as a training opportunity for graduate students at Harvard.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-23-7-A-63 CH-23-7-B-64	Massachusetts Association for the Adult Blind, Boston, Mass., Richard V. McCann.	May 1, 1963, to Apr. 30, 1964-- May 1, 1964, to Apr. 30, 1965-- Tentative-----	\$45,661 59,145 59,145

This project will demonstrate a method of referral, consultation, and education to provide generalized health and welfare services to the adult blind. It will attempt to combine a program of assessment and referral to the patient, and a program of consultation and education directed to the agencies providing the services. In this way it is hoped to overcome the tendency of the blind to rely on special, segregated services, and to develop techniques for making all community services available to them.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-23-10-A-63 CH-23-10-B-64	Massachusetts Health Research Institute, Inc., Boston, Mass.; Hugh L. C. Wilkerson, M.D.	Dec. 1, 1962 to Nov. 30, 1963--- Dec. 1, 1963 to Nov. 30, 1965---	\$70,381 80,659

The sponsor proposes to determine the role of a geriatric hospital in the development of appropriate out-of-hospital services for the chronically ill and aged in its service area. This project is to be accomplished by establishment of a closely integrated evaluation unit consisting of nine members, who will study the mechanism by which chronically ill persons can be kept in their own environment or hospitalized for restoration and returned to their communities as soon as possible. The basic objective is to define better methods of evaluation, referral, and continuity of care applicable to the growing geriatric problems of sickness and attending needs. These methods will show how existing institutional and community facilities can be most efficiently utilized in care of the geriatric patient. It is felt that the findings of this study could serve as a model, not only to other communities in Massachusetts but to the country as a whole.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-6-A-62 CH-34-6-B-63 CH-34-6-C-64	Medical & Health Research Association of New York City, Inc., New York, N.Y.; Jules E. Vandow, M.D., M.P.H.	May 15, 1962 to May 14, 1963-- May 15, 1963 to May 14, 1964-- May 15, 1964 to May 14, 1965--	\$175,695 184,804 214,239

The primary objective of this project is to study and demonstrate how the health resources of New York City can be brought to bear on the health problems of selective service rejectees, and to determine how volunteers from this group of rejectees can most effectively be referred to appropriate sources for medical care. Other objectives include the development of practical working relationships with a number of cooperating agencies and health resources, the identification of the causes for medical rejection, and the extent to which local health resources can provide remedial and rehabilitative services to rejectees. In addition, the demonstration is expected to identify the causes for delay in the discovery of medical defects prior to preinduction examination, and to examine the patterns of the rejectee's voluntary response to the offer of counseling and referral services.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-34-A-63 CH-34-34-B-64	Visiting Nurse Service of Rochester & Monroe County, Rochester, N.Y.; Elizabeth C. Phillips.	Sept. 1, 1963 to Aug 31, 1964--- Sept. 1, 1964 to Aug. 31, 1965--- Tentative-----	\$20,045 21,745 26,325

This project will build an additional type of community service to prevent unnecessary building of institutional beds and to make it safer and more desirable for a larger number of elderly and chronically ill persons to remain at home or to return home following group care. Using a personalized professional approach, it will attempt to identify needs of patients which have bearing on their mental and physical health. Through consultation, referral, and followup, it will utilize all appropriate existing community agencies in meeting these needs, and it will also develop additional services which are not available to the homebound. Volunteers will be used under professional direction and supervision.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-52-A-65	State Charities Aid Association, New York, N.Y.; Edward G. Lindsay.	Oct. 1, 1964, to Sept. 30, 1965.. Tentative-----	{ \$39,985 39,985 39,985

The establishment of a statewide information and consultation service in New York under this project will demonstrate how such a program can assist at the State level in bringing together official and voluntary agencies in a coordinate manner to identify gaps in services and plan jointly to fill the gaps. It will take necessary action at both State and local levels and directly assist local communities in appraising the needs of the chronically disabled, developing plans to meet the needs, and acting to implement such plans.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-16-A-62 CH-40-16-B-63 CH-40-16-C-64	Philadelphia Health Research Fund, Philadelphia, Pa.; Alfred S. Boguicki, M.D.	Aug. 1, 1962, to July 31, 1963--- Aug. 1, 1963, to July 31, 1964--- Aug. 1, 1964, to July 31, 1965---	\$73,033 67,911 67,425

The project is designed to demonstrate the value of a system of referral and field followup of Selective Service rejectees, with the local health department as the key coordinator, making maximum use of existing community resources by means of a variety of administrative devices. In addition, it is proposed to attempt to obtain insight into the attitudes toward health and illness, and toward opportunities provided for correction of defects. It is expected the project will provide a pattern for use in many other localities throughout the country.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-34-A-63 CH-40-34-B-64	Visiting Nurse Association of York & York County, York, Pa.; Mrs. Anna B. Leibfried, R.N.	July 1, 1963, to June 30, 1964--- July 1, 1964, to June 30, 1965 (2 years only).	\$9,399 5,045

This project is designed to provide better nursing care, and thus to promote the health and welfare of patients and their families, particularly the aging, by utilizing the services of a public health nurse supervisor who will work as a coordinator, in the various departments of the hospital and outpatient department, planning for referrals on the basis of individual patient needs to promote continuity of care. This will result in a more coordinated use of community resources which will be revealed in better care to more people.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-40-A-63 CH-40-40-B-64	Arthritis & Rheumatism Foundation, Eastern Pennsylvania Chapter, Philadelphia, Pa.; Harold R. Snyder.	Sept. 1, 1963, to Aug. 31, 1964-- Sept. 1, 1964, to Aug. 31, 1965 (2 years only).	\$30,250 33,000

Increasing evidence indicates that there are a great many chronically ill arthritic persons who do not require institutional care, but whose physical, social, and emotional health would be improved by guidance and motivation into normal cultural and social programs in a community. This project will develop and demonstrate a community recreation referral system for such persons. Two recreational professionals will be assigned to the sponsoring agency and will become the liaison persons between the agency, that recreation department, and the community. Patients will be evaluated medically, socially, and emotionally throughout the 2 years.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-09-8-A-64	District of Columbia Department of Public Health, Washington, D.C.; Dr. Murray Grant.	July 1, 1964, to June 30, 1965--- Tentative-----	\$75,301 { 78,616 56,965

This project will create a central registry of all diagnosed cases of rheumatic fever and rheumatic heart disease on record for the last 5 years, obtaining records from the District of Columbia Health Department, the six large cooperating hospitals, and from cooperating private physicians. Followup service will be provided to assure that those on the registry remain under medical supervision. Drugs for secondary prophylaxis for indigent and medically indigent patients on the registry will be provided. An adult rheumatic fever clinic for the medically indigent will be established. Phase II of the project will conduct an intensive study of delinquent cases of rheumatic fever to determine why people have stopped prophylaxis and have been lost to medical supervision.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-19-5-A-64 CH-19-5-B-65	Information Center for the Chronically Ill, Louisville, Ky.; Ruth M. Dalton.	Dec. 1, 1963, to Nov. 30, 1964-- Dec. 1, 1964, to Nov. 30, 1965--	\$46,015 { 47,525 40,282

The main objective of this project is to demonstrate that an information, consultation, and referral center can administer efficiently and economically a home-aid program. It will demonstrate that such a center can become a research and demonstration agency focusing on the needs of the chronically ill, and on the development and improvement of necessary community resources, and that it can successfully promote and administer a new and needed program in the community. It will also study administrative costs for home-aid programs when attached to a centralized service, such as an information and referral center.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-35-1-A-62 CH-35-1-B-63 CH-35-1-C-64	Chronic Illness & Rehabilitation Foundation, Inc., of Guilford County, Greensboro, N.C.; Mrs. Sue S. McClellan.	Sept. 1, 1962, to Aug. 31, 1963-- Sept. 1, 1963, to Aug. 31, 1964-- Sept. 1, 1964, to Aug. 31, 1965--	\$38,375 45,264 38,375

The foundation is to provide a coordinated home care and information and referral service for the chronically ill and aged in Guilford County, which includes two urban communities and a rural population. It is designed to reach those who are able to pay all or part of the cost of care and those who cannot pay anything. The county health department and the county welfare department as well as other local organizations are cooperating in the project. The project will demonstrate an approach to bring communities together into a single program to study their problems and needs, plan to meet these needs, and activate a program of coordinated services.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-49-5-A-65	Health-Welfare-Recreation Planning Council, Norfolk, Va.; George F. Rice.	Mar. 1, 1965, to Feb. 28, 1966-- Tentative-----	\$35,511 33,400 35,001

This project will institute a new program in southeastern Virginia designed to demonstrate the value of a comprehensive approach in the distribution of health information through a health information-referral planning center within the largest metropolitan area of the State. The council will centralize current information and disseminate it to the general public and providers of health services, and, through an economical and efficient method of compiling data, proposes to set up an approach for the planning of community health services to be used areawide.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-10-5-A-63 CH-10-5-B-64 CH-5-10-C-65	University of Florida College of Nursing, Gainesville, Fla.; June G. Remillet.	Dec. 1, 1962, to Nov. 30, 1963--- Dec. 1, 1963, to Nov. 30, 1964--- Dec. 1, 1964, to Nov. 30, 1965---	\$21,936 22,462 23,569

This project is directed to the development of a method of communication which will assure continuity of patient care following discharge from the hospital into the patient's home, either as an inpatient or outpatient. It is expected to demonstrate how a statewide referral service can work on a routine basis and evaluate its usefulness and effectiveness.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-24-8-A-64 CH-24-8-B-65	Commission on Professional & Hospital Activities, Ann Arbor Mich.; Vergil N. Slee, M.D.	Mar. 1, 1964, to Feb. 28, 1965--- Mar. 1, 1965, to Feb. 28, 1966 -- Tentative-----	\$84,277 83,890 86,633

The purpose of this study is to develop an integrated information system for local community health departments using the computer facility of the sponsor in cooperation with the Washtenaw County Health Department. Information will be collected and reported only once, and the electric computer system will process, compile, and rearrange this information in as many different ways as might be useful to community, county, State, Federal Government and other interested agencies. Thus more information can be provided in readily assessable form and with greater economy of effort in accumulating.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-17-A-64	Toledo Council of Social Agencies, Toledo, Ohio; Miss Mary Hayes, B.S., M.P.H.	Apr. 1, 1964, to Mar. 31, 1965-- Tentative-----	\$25,580 25,580 26,580

The primary objective of this project is to assist the community in making more effective use of its health, welfare, and recreational facilities through an information, counseling and referral center. The program will be under the administration of the Toledo Council of Social Agencies and expects to eliminate duplication of services by several agencies, give short-term counseling by social casework method, and disclose a significant number of individuals with unmet needs. Such a center will be able to interpret available services provided by agencies, and will promote a coordinated effort by all agencies to meet needs of the community.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-27-12-A-63 CH-27-12-B-64	Regional Health and Welfare Council, Kansas City, Mo.; Edward H. Tuttle.	Aug. 1, 1963, to Sept. 30, 1964... Oct. 1, 1964, to Sept. 30, 1965... Tentative.....	\$63,589 61,144 63,983

Through this project an information, counseling, and referral center will be set up in the Kansas City metropolitan area. This will be a voluntary organization of citizens who will plan and coordinate services in health and welfare for the area. The funds will be used to provide information to those serving the chronically ill and aging, to provide advice to the patient, or his family, concerning, the appropriate agency or institution for his problem, and to test whether such a center can be of use in coordinating out-of-hospital care.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH-38-5-A-63 CH-38-5-B-64 CH-38-5-C-65	Oklahoma State Department of Health, Oklahoma City, Okla.; Forest R. Brown, M.D.	Mar. 1, 1963, to Feb. 29, 1964... Mar. 1, 1964, to Feb. 28, 1965... Mar. 1, 1965, to Feb. 28, 1966...	\$43,642 27,541 28,538

This project will demonstrate how a State department of health in a rural State can provide leadership and service in combating the effects of chronic illness and aging by means of an information, referral, and consultative service. A statewide survey of resources in the 77 counties of the State will be conducted with all social agencies, organizations, health and welfare units, etc., being contacted. Information gathered will be used to provide and maintain a file on all resources in the State for the chronically ill and aged. Field consultants will report health and social problems from which a central index will be compiled. Local planning bodies may then be able to determine the extent and kind of services required in various communities and make referrals.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII-----	CH-06-2-A-62 CH-06-2-B-63	Colorado State Department of Public Health, Denver, Colo.; John A. Lichty, M.D.	June 1, 1962, to May 31, 1963... June 1, 1963, to May 31, 1964, (2 years only).	\$11,500 12,228

This project is a demonstration to the community and its social agencies, and to the patients themselves, of the leadership a local health department can assume in resolving the complexity of health-related problems of the chronically ill and their families. This will be accomplished by setting up a central referral, coordination, and consultation service in the local health department. Where multiple needs exist, services are to be coordinated. This service is staffed by a medical social worker and a part-time clerk to whom health problems can be referred from any source in the community for either direct service or consultation.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII-----	CH-06-7-A-65	Colorado State Department of Public Health, Denver, Colo.; Vanetin E. Wohlauer, M.D.	Oct. 1, 1964, to Sept. 30, 1965... Tentative.....	\$57,644 61,131 63,690

Because of the apparent need of men rejected from the Armed Forces for medical reasons for health counseling, guidance, and referral, the Colorado Department of Public Health will operate a statewide project to carry out such a service. Each person rejected for medical reasons will be referred to the health referral center by the staff at AFES. Professional personnel will make a determination as to the possibilities of rehabilitation, cure and/or para-medical benefits in the fields of psychiatry, physical medicine, and dentistry. The rejectee for whom such assistance is believed to be in order will be referred to the proper agency or persons who can help him in making arrangements for the necessary services and followup. Evaluation will compare the differences of the problems and programs as they exist in a primarily rural area with those in completely urban areas.

PHS region	Project No.	Grantee and project director	Period	Grantee
IX-----	CH-03-11-A-65	Community Council (Maricopa County), Phoenix, Ariz.; Milton Gan, M.S.W.	Nov. 1, 1964, to Oct. 31, 1965-- Tentative-----	\$36,919 29,387 35,097

This project will establish and maintain a central service which will provide information and/or referral to individuals and agencies with regard to the extent and availability of all health services in the area. It will also experiment with methods and procedures for systematically collecting, maintaining, and using information on the variety of agency policies regarding referrals and admissions. Experimentation will also be made as to what happens to people once they are referred and how such data can be used in helping the community to remodel its structure and program of services.

PHS region	Project No.	Grantee and project director	Period	Grantee
IX-----	CH-05-18-A-63 CH-05-18-B-64	United Community Fund of San Francisco, San Francisco, Calif.; Martha Burt.	Mar. 1, 1963, to Oct. 31, 1964-- Nov. 1, 1964, to Oct. 31, 1965-- Tentative-----	\$32,150 34,461 21,091

The project will organize and administer a central medical social service bureau for private patients on referral from physicians, on a fee-for-service basis, with the objective of improving the personal relationships and environmental factors of patients under the care of private physicians. It will be established to serve institutions where it does not presently exist and will attempt to prove the value of medical social work to hospitals which do not now maintain this type of patient service. It is expected that at the end of a 5-year period the program will be self-supporting.

PHS region	Project No.	Grantee and project director	Period	Grantee
IX-----	CH-05-22-A-63 CH-05-22-B-64	San Mateo County Department of Public Health and Welfare, San Mateo, Calif.; Pierre Salmon, M.D.	July 1, 1963, to June 30, 1964-- July 1, 1964, to June 30, 1965-- Tentative-----	\$61,567 76,276 64,268

The primary objective of the sponsor is to establish a satisfactory system of patient classification for those patients in need of long-term supportive and remedial care. Patients who are currently receiving long-term medical or nursing care under the auspices of the department of public health and welfare will be initially deployed, and their placements reviewed at intervals of 3 to 4 months for appropriateness. A referral system for nonindigent patients needing long-term care is also planned.

VIII. PUBLIC EDUCATION AND COMMUNICATION

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-32-1-A-62 CH-32-1-B-63 CH-32-1-C-64	United Hospitals of Newark, Newark, N.J.; Howard R. Jones.	July 16, 1962, to July 15, 1963... July 16, 1963, to July 15, 1964... July 16, 1964, to July 15, 1965...	\$15,100 15,450 14,891

This project is directed to the development of integrated hospital-community educational services for chronically ill patients in the community through a hospital-based health education program. The sponsor proposes to determine the educational interest and needs of chronically ill patients and their families prior to and following hospitalization, assess hospital, and community resources for meeting these needs, and measure the effectiveness of educational services in reducing relapse and readmission rates.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-09-7-A-63 CH-09-7-B-64	Health & Welfare Council of the National Capital Area, Washington, D.C.; Everett S. Cope.	July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965... Tentative.....	\$32,800 46,070 46,175

The purpose of this project is to deliver existing medical knowledge and health services to the low-income families living in today's urban neighborhoods. Three indigenous neighborhood health aids who are familiar with the way of life of the people of the area will be hired and trained. They will serve as a bridge between professional and lay patterns of language, health attitudes, and practices. They will be supervised by the medical personnel of the department of public health and will work in conjunction with a project nurse. Intake and evaluation plans will be coordinated into the existing casework program which includes research consultation.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-11-8-A-64	Ferst Research Center, Pied- mont Hospital, Atlanta. Ga.; Mary Sue Pritchett.	June 1, 1964, to May 31, 1965... Tentative.....	\$39,560 41,100 40,000

The shortage of qualified, trained medical personnel cannot meet the educational demand presented by an ever-increasing population unless better methods of communication are employed to speed up the process of education and thereby more fully utilize the talents and extend the capabilities of the limited number of educators. In a selected group of community health agencies, a study will be made of the basic communications problems in order to develop low-cost, simple communications aids (audio, visual, and audiovisual materials and devices) to fit particular teaching situations which affect community health—patient and family education, personnel training, liaison between agencies, etc.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH-55-9-A-63	American Pharmaceutical Association, Washington, D.C.; George B. Griffen- hagen.	June 1, 1963, to Aug. 31, 1964 (1 year only).	\$100,800

This project is designed to determine the effectiveness of the community pharmacy as a community health education center. Racks displaying printed material on health matters will be installed in a sample of community pharmacies

across the Nation. Changes in attitudes and opinions of patrons of these pharmacies and in the pharmacists themselves will be evaluated to determine the effectiveness of the program.

IX. ORGANIZATION TO PROVIDE HEALTH SERVICES

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-07-2-A-62 CH-07-2-B-63 CH-07-2-C-64	Connecticut State Department of Health, Hartford, Conn.; Mrs. Norma Lundquist.	Sept. 1, 1962, to Aug. 31, 1963... Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965...	\$26,794 25,325 24,222

The State health department will demonstrate the value of nursing supervision in upgrading public health nursing services and show how one supervisor can supervise the nurses of several small agencies. Another objective is to demonstrate the value of generalized public health nursing services, especially out-of-hospital nursing care of the sick in rural areas, and motivate community leaders in the State to make provision for this service.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-07-3-A-63 CH-07-3-B-64 CH-07-3-C-65	Dental Clinic Society of New Haven and Gerontological Committee of the Connecticut State Dental Association, New Haven, Conn.; Gerald L. St. Marie, D.D.S.	Aug. 13, 1962, to Aug. 12, 1963... Aug. 13, 1963, to Aug. 12, 1964... Aug. 13, 1964, to Aug. 12, 1965...	\$29,762 30,795 31,904

The sponsor is developing a community dental care program for homebound and chronically ill and aged persons. Study will be made of the actual costs of providing dental services and ascertain its economic feasibility as a community health service. Dental services will be provided in the home, community clinic, or private office, depending on the extent of the patient's disability as determined by the physician or facility or both. Charges will be made for the services. However, the project is designed so that no person will be refused service because of inability to pay.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-07-4-A-62 CH-07-4-B-63 CH-07-4-C-64	Connecticut State Health Department, Hartford, Conn.; Harold S. Barrett, M.D.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$65,545 58,521 46,094

This project involves three major areas: organization for and financial assistance in developing homemaker services; the design of courses, preparation of materials and exhibits for use in training homemakers and the holding of seminars, institutes for supervisors, directors, and other personnel; and the evaluation of organized homemaker services. The project will develop guidelines and criteria for homemaker programs, at both State and local levels, and provide new information and identify the role of a State health department in homemaker programs useful on a regional or national basis.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-07-11-A-65	Yale University, New Haven, Conn.; Roy M. Acheson, D.M.	Nov. 1, 1964, to Oct. 31, 1965... Tentative.....	\$92,991 135,096 112,003

This project will define a group of people in five socioeconomic classes in the city of New Haven who are suffering debilitation from joint diseases. It will

measure the severity and causes of disability arising from joint disease, measure the source and effectiveness of medical care being provided, and plan future medical services in New Haven for such people.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-07-12-A-65	City of New Haven Department of Public Health, New Haven, Conn.; Carter Marshall, Jr., M.D., M.P.H.	Sept. 15, 1964, to Sept. 14, 1965. Tentative-----	\$57,348 58,052 58,448

This project is one unit of the HEW-PHA concerted services program, a program conceived as an approach to intervening in and destroying the cycle of dependency and poverty. It will be conducted in the Elm Haven housing project, and will develop techniques of identifying and interpreting health needs, develop an action program which will arrange for the delivery of appropriate health programs, provide the appropriate public health services, and provide assistance to project residents in recognizing their family's health needs and help them make the most appropriate use of services available to them. Evaluation will be by the project staff with the help of Yale University Department of Epidemiology and Public Health.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-23-18-A-64	Berkshire Rehabilitation Center, Pittsfield, Mass.; Dr. Vincent T. Barnaba.	May 1, 1964, to Apr. 30, 1965--- Tentative-----	\$56,150 43,350 42,450

This project will incorporate into the medical care of a semirural area the concepts and skills of modern rehabilitation of persons with chronic illnesses of all kinds regardless of the person's age, income or medical location. It will define and distinguish those aspects of medical rehabilitation which should be provided by secondary rehabilitation centers, general practitioners or other specialists in the course of their regular care of patients, or an affiliated primary rehabilitation center. It will also study the amounts and patterns of medical rehabilitation services provided in this area by a physiatrist and by other categories of professional staff of a secondary rehabilitation center.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-23-19-A-64	Age Center of Worcester Area, Inc., Worcester, Mass.; Samuel Bachrach, M.D.	June 1, 1964, to May 31, 1965--- Tentative-----	\$49,831 55,590 57,481

The Age Center will demonstrate the use and usefulness of a community-sponsored multiservice center for the aging which will provide for and coordinate a variety of necessary health and social services for older people well enough to come to the center and chronically ill residents of nursing homes. It will provide consultant service in the fields of nursing, nutrition and social work to nursing homes requesting it, and physical therapy and recreation therapy services to patients living in certain nursing homes with which contract agreements have been made. It will also provide for the systematic training of volunteers willing to serve as "friendly visitors," recreation aids, staff members of nursing homes and students seeking careers in health and social work professions.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-31-5-A-63 CH-31-5-B-64 CH-31-5-C-65	New Hampshire State Council on Aging and Claremont General Hospital, Claremont, N.H.; Garner C. Goodwin.	Mar. 1, 1963, to Feb. 29, 1964-- Mar. 1, 1964, to Feb. 28, 1965-- Mar. 1, 1965, to Feb. 28, 1966--	\$10,000 7,000 5,000

This project will sponsor and establish an outpatient diagnostic and treatment clinic for persons 60 years of age and over which will serve as a detection and prevention medium for conditions leading to disability. It hopes to establish the value of such a clinic by determining whether or not the clinic will be used by the older citizens of the area; through the use of hospital and casework records determine that the clinic is in fact providing a medical service which would not have been provided otherwise; and gather information on the amount of known and unknown disease and disability found through contact with the clinic.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-42-1-A-62 CH-42-1-B-63 CH-42-1-C-64	Rhode Island Department of Health, Providence, R.I.; John T. Tierney, M.S.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$13,724 13,178 12,930

The purpose of this project is to establish a rehabilitation council—under the coordinating sponsorship of the State health department—as a principal planning agency for health services in the State. Establishment of such a council is the first step in the long-range planning program to integrate rehabilitation services now supplied by various rehabilitation agencies so that a more effective approach can be made to meet the needs of the chronically ill and aged. The State health department provides staff for the council which serves as the main body for interpretation of rehabilitation to the community and to special services related to rehabilitation.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-1-A-62 CH-34-1-B-63 CH-34-1-C-64	Patient Care Planning Council of Monroe County, Rochester, N.Y.; Miss Jane Robertson.	Mar. 1, 1962, to Feb. 28, 1963... Mar. 1, 1963, to Feb. 29, 1964... Mar. 1, 1964, to Feb. 28, 1965...	\$8,000 8,225 8,600

Project grant funds are being used to help finance a study of health needs of the chronically ill and aged and utilization of existing facilities and services by the Patient Care Planning Council of Monroe County which makes recommendations to appropriate governmental and nongovernmental bodies on development of home care, ambulant, and institutional patient care services and facilities. On the basis of the results of this study, the council will make recommendations as to a balanced program of institutional and home care services and facilities for appropriate patient care.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-3-A-62 CH-34-3-B-62 CH-34-3-C-64	Medical & Health Research Association of New York City, Inc., New York, N.Y.; Nicetas Kuo, M.D., M.P.H.	Apr. 2, 1962, to Apr. 1, 1963... Apr. 2, 1963, to Apr. 1, 1964... Apr. 2, 1964, to Apr. 1, 1965...	\$85,295 123,202 124,272

A project to further develop a pilot program of health and medical care for the elderly initiated in a public housing project. Through this program it is planned to identify the health and medical needs of an elderly population living in a public housing project, develop a system acceptable to the group for meeting these needs through coordinated efforts of cooperating agencies, to integrate this system into regular ongoing programs in effect, to maintain as long as possible the ability of these older people to live independently and as active members of their community, and to make an evaluation of the overall program and its component parts. Services will be centered in the health maintenance clinic of the housing project, but will, when indicated, be offered in the hospital outpatient department, or through the hospital home care program, or any combination of these.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-8-A-62 CH-34-8-B-63 CH-34-8-C-64	Monroe County Department of Health, Rochester, N.Y.; Margaret L. Rathbun, M.D., M.P.H.	Aug. 1, 1962, to July 31, 1963---- Aug. 1, 1963, to July 31, 1964---- Aug. 1, 1964, to July 31, 1965----	\$28,498 34,393 26,481

The sponsor will study whether the assignment to hospitals of qualified public health nursing personnel might shorten the hospital stay and improve the medical, nursing, and social management of patients requiring home care by advance planning for the proper level of care and services required. The nursing personnel would be under the administrative control and guidance of the county health department. In addition, the study is to determine whether this method of screening, evaluation, and planning for patient care at home is effective. Three nurses are assigned in three different hospitals in the county to participate in the functions planned, with a fourth nurse assigned to followup of patients for purposes of the study.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-18-A-63	Health Association of Niagara County, Inc., Niagara Falls, N.Y.; Lawrence T. Snyder.	July 1, 1963, to June 30, 1965---- Tentative-----	\$16,825 16,825 16,825

This project will document the expansion of an information and referral service now existing through the utilization of an administrative assistant to complement the social worker. Roles of a medical consultant and a public health nursing consultant in the service will be identified. It is hoped, through such a service functioning within the framework of a voluntary health agency, to bring about greater coordination and improved utilization of existing out-of-hospital services, thereby aiding physicians, agencies, patients, and their families.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-31-A-63 CH-40-31-B-64 CH-40-31-C-65	Home for Crippled Children, Pittsburgh, Pa.; Miss Katherine Patton.	Mar. 1, 1963, to Feb. 29, 1964--- Mar. 1, 1964, to Feb. 28, 1965--- Mar. 1, 1965, to Feb. 28, 1966---	\$41,350 45,620 47,820

This project will demonstrate the effectiveness of rehabilitation services by continued followup of patients. It plans to develop, test, improve, and demonstrate procedures and techniques with patients which will result in earlier diagnosis and evaluation, and a reduction in the length of the inpatient treatment period. It will also develop an ongoing case record for periodic reevaluation of patients to determine the effectiveness of the services provided.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-53-A-64 Supplement A-65	Allegheny County Medical Society Foundation, Pittsburgh, Pa.; Florence Marcus, M.D.	May 1, 1964 to Apr. 30, 1965--- Tentative-----	\$62,070 9,100 60,850 74,150

A health care team composed of a general practitioner, a social worker, a public health nurse and office personnel will be located in a public housing community of 5,000 population to provide health care services coordinated with other health as well as welfare services in the community. The project will demonstrate that, by making family health care services easily and quickly available in an otherwise "medically isolated" community, the health level of the population can be more effectively and efficiently utilized. The project will also determine the costs of such health care and the degree to which such care can become self-supporting, or the amount of community subsidy it requires for continuation.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-19-6-A-64 CH-19-6-A-65	Kentucky State Department of Health, Frankfort, Ky.; Russell E. Teague, M.D.	Jan. 15, 1964 to June 30, 1965-- July 1, 1964 to June 30, 1965----	\$327,100 77,000

A demonstration project will be established which will show how a comprehensive screening, evaluation, and followup program can be operated in a chronically depressed rural area in which transportation is a major problem. Two screening teams plus an evaluation team will coordinate their activities with existing programs and facilities. Families and groups of people will be transported to the screening areas and to the diagnostic center as needed. Emphasis will be placed on referring all cases where a diagnosis has been established to the most appropriate source of treatment.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-22-5-A-63 CH-22-5-B-64	Baltimore City Health Department, Baltimore, Md.; Mason Lord, M.D., Matthew Tayback, Sc. D.	Jan. 1, 1963 to Mar. 31, 1964---- Apr. 1, 1964 to Mar. 31, 1965---- Tentative-----	\$44,925 70,182 47,804

Under this project, a coordinating office of community services for chronic disease will be established which will attempt to coordinate for the chronically ill the use of home, office, and clinic care; general hospital care; chronic disease hospital care; and nursing home or foster home care. It is believed that the lack of such coordination results in excessive demands for chronic disease hospital care and nursing home care. A team, consisting of a physician, social worker, and public health nurse, will demonstrate the manner in which it can function to provide preadmission patient evaluation and postdischarge planning and case supervision.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-35-5-A-63 Supplement A-65	North Carolina Hospital Education & Research Foundation, Raleigh, N.C.; Robert R. Cadmus, M.D.	Apr. 1, 1963, to Mar. 31, 1965 (full funded).	\$56,713 3,100

The purpose of this project is to study the organization of ambulance service in the State, using a questionnaire technique. Lack of appropriate transportation often complicates treatment of home care patients, and it is expected from the data collected and evaluated in this study to develop guidelines for community action for studying and meeting the patient transportation problem in this and other States.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-41-2-A-63 CH-41-2-B-64 CH-41-2-C-65	Puerto Rico Department of Health and Welfare, San Juan, P.R.; Raul A. Munoz.	Dec. 1, 1962, to Nov. 30, 1963-- Dec. 1, 1963, to Nov. 30, 1964-- Dec. 1, 1964, to Nov. 30, 1965--	\$46,550 88,205 115,200

The basic objective of the project is to provide information for use in planning and evaluating health programs in Puerto Rico through a continuing master sample survey. This survey will seek to identify and characterize the dimensions and magnitude of chronic illness and other health problems as they prevail among family units, as well as individuals. It will also seek to indicate the effect of the health and welfare programs created to deal with these problems, and thus provide a sounder basis for decisions as to priorities and allocations of scarce resources of money and personnel.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-41-7-A-65	University of Puerto Rico, San Juan, P.R.; Norman O. Harris, D.D.S.	Oct. 1, 1964, to Dec. 31, 1965--- Tentative-----	\$21,666 18,998 4,701

This project will demonstrate the value and operational feasibility of a preventive dentistry school program, utilizing a new rapid methodology for accomplishing a prophylaxis with a stannous fluoride paste. It will verify the anticariogenic effectiveness of a twice-a-year rapid prophylaxis-stannous fluoride procedure accomplished within a school, using first and second grade children, and will determine the professional manpower and supporting facilities which would be necessary to accomplish needed treatment under a referral system.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-01-1-A-62 CH-01-1-B-63 CH-01-1-C-64 Supplement C-65	Jefferson County Health Department, Birmingham, Ala.; Polly Ayers, D.D.S	June 1, 1962, to May 31, 1963--- June 1, 1963, to May 31, 1964--- June 1, 1964, to May 31, 1965---	\$33,012 30,640 30,384 2,082

This project is to demonstrate how a dental school (University of Alabama) and a health department (Jefferson County Department of Health) can cooperate in providing services for the chronically ill and aged by establishing a special center for training students in the techniques of providing such services for both ambulatory and nonambulatory individuals. Plans call for establishment of a two-chair dental clinic in a health center. Two dental students will work either in this clinic or out from the clinic 5 half-days a week. A hygienist is to work half time with the students and half time with prophylaxes and X-rays for ambulatory patients. Also, a dental assistant is to work full time in the clinic. Existing equipment of the health center is being renovated for use on the project. The following services are to be rendered for chronically ill and aged patients: operative dentistry, full and partial dentures, edentulous radiographic surveys, cleaning of natural and artificial teeth, and oral hygiene instruction.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-10-1-A-62 CH-10-1-B-63 CH-10-1-C-64	Florida State Board of Health, Jacksonville, Fla.; Jean Jones Perdue, M.D.	June 1, 1962, to May 31, 1963--- June 1, 1963, to May 31, 1964--- June 1, 1964, to May 31, 1965---	\$49,677 47,607 46,098

A project to demonstrate that continuity of medical care and the rehabilitative needs of persons with chronic diseases can more adequately be met by existing community resources through advance planning and well-developed coordinated efforts. Patients for the project are selected from those referred to the Department of Welfare for continuing medical care. Evaluations are to be made to determine the medical, nursing, rehabilitative, and socioeconomic needs of these persons. Based on the evaluations and recommendations, a plan for continuing care will be formulated through case conferences. Comprehensive treatment plans are also formulated for each individual with followup provision. Representatives of cooperating agencies are invited to participate in formulating plans for cases in which they have particular interest. It is expected that the community agencies will continue the coordination of services as developed in the project.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-10-4-A-62	Florida State Board of Health, Jacksonville, Fla.; Mary K. Pratt, R.N., M.A.	July 1, 1962, to Sept. 30, 1964 (full funded).	\$84,917

The project is a study to determine the nature and magnitude of total extra-hospital nursing needs—those not normally met by hospitals and nursing homes—by conducting interviews and making observations in a representative sample of households in Pinellas County. The same methods as those applied in the Johns Hopkins University study conducted in Butler County, Pa., will be used, thereby testing the usefulness of the previous method as a means of obtaining data which will permit generalizations broadly applicable to other segments of the population. Interviews and observations are to be carried out by specially trained and experienced public health nurses. Analysis and evaluation will be made of the nurse interviewers-observers' judgments as to needs and detailed evidences as to household situations and problems.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-11-1-A-62	Emory University School of Nursing, Atlanta, Ga.; Miss Lillian Bischoff.	July 1, 1962, to June 30, 1963---	\$51,944
	CH-11-1-B-63		July 1, 1963, to June 30, 1964---	44,826
	CH-11-1-C-64		July 1, 1964, to June 30, 1965---	40,035

Through the establishment of a health district serviced by Emory University School of Nursing, the project sponsor will identify the nursing and related needs of persons in the middle or upper socioeconomic level who are chronically ill or aged, and demonstrate the contribution of high quality public health nursing to meeting the needs of such persons on a fee basis. In addition, it will identify the need for additional services such as homemaker meals-on-wheels and occupational therapy and promote physician utilization of nursing and rehabilitation services in the home on a fee-for-service basis. This project represents a first attempt to study an entire community to identify nursing needs and needs for other related services of economically independent persons.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-11-9-A-64	Richmond County Department of Public Health and Augusta Area Tuberculosis Association, Inc., Augusta, Ga.; Frank P. Anderson, M.D.	Sept. 1, 1964, to Aug. 31, 1965--	\$71,335
			Tentative-----	79,431 89,273

This project will establish a coordinated community service to rehabilitate and educate patients with chronic pulmonary diseases in the Augusta area. Diseases included will be chronic bronchitis, chronic obstructive pulmonary emphysema, bronchiectasis, and chronic bronchial asthma. The service will provide treatment, using the group therapy approach; evaluate patients and provide services in forms of out-patient care; educate and train patients, their families, and the laity; and orient and educate professional individuals. Complete evaluations will be included.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-45-7-A-64	Meharry Medical College, Nashville, Tenn.; Eugenia L. Mobley, D.D.S., M.P.H.	July 1, 1964 to June 30, 1965---	\$55,703
			Tentative-----	73,357 72,904

This project is designed to develop a community dental care program for the chronically ill and aged. The sample population will consist of both institutionalized and noninstitutionalized indigent residents of Davidson County. Characteristics of this population will be measured in terms of the need for full mouth rehabilitation, the extent to which patients can benefit from rehabilitation, the type, frequency and cost of the dental services needed for their rehabilitation, and the effects of such rehabilitation on the community in social and economic terms. The project will determine the prevalence and incidence of dental health needs, evaluate the present methods and means by which these needs are being met, and establish the level of dental care in terms of past care and present need.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-24-11-A-65	University of Michigan, Ann Arbor, Mich.; Vlado A. Getting, M.D.	Jan. 1, 1965, to Dec. 31, 1965--- Tentative-----	\$88,962 94,440 98,472

The ultimate goal of this project is to improve the status of organization and finance of community health services in Michigan. It will test the extent to which systematic involvement of top decisionmakers in the analysis of the problems connected with provision of these services will lead to positive action to change the system for the better and result in actual and significant modifications of the current pattern of operations. The project will be under the direction of the University of Michigan with the Michigan Health Officers Association and the Michigan Department of Health as cosponsors. The working committee will be made up of 40 highly influential citizen leaders in the State.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-10-A-63 CH-37-10-B-64 CH-37-10-C-65	Mount Sinai Hospital of Cleveland, Cleveland, Ohio; Sidney E. Wolpaw, M.D.	Dec. 15, 1962, to Dec. 14, 1963-- Dec. 15, 1963, to Dec. 14, 1964-- Dec. 15, 1964, to Dec. 14, 1965--	\$58,816 49,986 51,309

This study is to demonstrate the feasibility, cost, and value of providing a full range of out-of-hospital health services to elderly residents of a public housing project. The findings are expected to contribute knowledge on the selection of those elements of health care that can economically be provided to elderly persons in a residential setting. Comparison will be made of the experience of residents in this project with an equivalent population in a nearby housing project without a medical program. This will make it possible to evaluate and document the usefulness and health value of specific out-of-hospital services. Such data would provide guidance to housing authorities, health agencies, and community planners on needs, facilities, cost problems, and cost solutions.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-11-A-63 CH-37-11-B-64	Welfare Federation of Cleveland, Cleveland, Ohio; Mildred C. Barry.	June 1, 1963, to May 31, 1964-- June 1, 1964, to May 31, 1965-- Tentative-----	\$25,000 34,550 25,000

This project will provide a means by which a group of the community's decisionmakers can develop acceptable community health goals and a model of a health community; identify and reduce gaps between the present situation and goals; establish priorities; and set into motion a program of implementation. The study will be a departure from the traditional in that it starts with goal formulation and development of a model. It will be a total approach covering all aspects of health in a metropolitan community and utilize a new system of classifying health areas. It provides for extensive use of consultation service from outside and substantial involvement of community leaders.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-14-A-64	Cleveland Health Foundation, Cleveland, Ohio; Glenn Wilson.	Jan. 1, 1964, to June 30, 1965---	\$100,000

This project is designed to demonstrate and evaluate the effectiveness and cost of a complex of health maintenance services, especially directed at the problems of aging and chronic illness, and organized in the setting of a consumer-sponsored comprehensive service, prepaid group practice program. Currently

operating medical care plans have not found it financially or organizationally feasible to include significant health maintenance services within the regular benefit-premium structure. The need remains to test the feasibility of just such incorporation into the routine activities of a prepaid medical service program. This will be done in the environment of and with the cooperation of a university medical center.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-18-A-64	Highland View Hospital, Cleveland, Ohio; Dr. Howard Barry Waldman.	May 1, 1964, to Apr. 30, 1965-- Tentative-----	\$56,073 55,140 59,274

This project proposes to gain information and experience regarding the factors involved in providing dental care to the chronically ill and aging using an outpatient clinic to supplement existing available means, and establish a criteria for home versus out-of-home dental care for this group. The knowledge gained will be utilized to promote the integration of the dental care of this population with the existing community health agency activities and to investigate means to incorporate this program as a permanent service of the local community.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-25-3-A-62 CH-25-3-B-63 CH-25-3-C-64	St. Paul Outpatient Center, Inc., St. Paul, Minn.; Win- ston R. Miller, M.D., F.A.C.P.	Sept. 1, 1962, to Aug. 31, 1963-- Sept. 1, 1963, to Aug. 31, 1964-- Sept. 1, 1964, to Aug. 31, 1965--	\$115,732 111,050 117,829

A project to develop further the potential of a unique and significant experiment in the administration of out-of-hospital medical care. Among the objectives are the provision of comprehensive, coordinated out-of-hospital care for the medically indigent persons on a part-pay basis and the evaluation of this method of medical care administration and demonstration of its value to the public and the various health professions. Five private hospitals join to form an outpatient department and participate in its operation.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-25-11-A-64	Department of Public Health and Welfare, Rochester, Minn.; Viktor O. Wilson, M.D., M.P.H.	July 1, 1964, to June 30, 1965-- Tentative-----	\$11,484 10,988 11,264

This project will develop a program utilizing community services to reduce the number of recurrences of congestive heart failure and to decrease the frequency of hospital admissions because of these recurrences. It is planned to accomplish this through the use of various paramedical professions at the community level as an adjunct to private physicians in the care of the patient. The program will incorporate regular visits of public health nurses to the home of congestive heart failure patients; dietary counseling services; and the use of a social worker to assist in the correction of socioeconomic problems which might arise. A further objective of the project is to undertake an epidemiological study of congestive heart failure.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-27-7-A-63 CH-27-7-B-64	Health & Welfare Council of Metropolitan St. Louis, St. Louis, Mo.; Robert C. Lin- strom.	Apr. 1, 1963, to Mar. 31, 1963-- Apr. 1, 1964, to Mar. 31, 1965-- Tentative-----	\$62,431 65,487 68,350

A project to determine the optimum method of providing homemaker-housekeeper services to the chronically ill and aged by working with voluntary and governmental health and welfare agencies. One of the issues to be resolved is the location of such services in the array of health and welfare services offered in the community. Another is whether homemaker-housekeeper services in the family or child welfare field are similar and should be related to the same services for the chronically ill and aged. It is expected to obtain pertinent information on such aspects of homemaker services as the effect of certain auspices on services and the possibility of providing certain centralized services.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH-46-7-A-64	Texas Institute for Rehabilitation & Research, Houston, Tex.; Marvin E. Mergele, D.D.S.	Apr. 1, 1964, to Mar. 31, 1965-- Tentative-----	\$46,338 38,049 36,887

This project will evaluate the benefits of a multidisciplinary approach in providing dental care for the elderly, handicapped, disabled, and the chronically ill. Its aim is to accumulate field data about the special dental, physiological, personal, and social problems of these groups which will lead to better techniques and treatment, and utilize results from a prototype program which will demonstrate the need for programs of this type. It will establish a basis for determining the type of care needed plus a mechanism for delivery of such care.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH-46-8-A-65	Dallas Dental Public Health Division, Dallas, Tex.; E. W. Hornish, D.D.S.	Award not made as of Dec. 31, 1964.	\$38,307 36,412 31,776

This project will develop a program designed to provide complete dental services to the chronically ill, the aged, and the homebound living in nursing homes and private residences in Dallas, making the best use of local resources and demonstrating the value of continuing this project as a regular part of the total community health program.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-51-2-A-63 CH-51-2-B-64	University of Washington, Seattle, Wash.; Justus F. Lehmann, M.D.	July 1, 1963, to June 30, 1964-- July 1, 1964, to June 30, 1965-- Tentative-----	\$29,500 29,500 29,500

The purpose of this project is to aid the process of returning patients to the community and daily living. It will develop a series of nonhospital controlled environmental situations for the placement of chronically disabled patients in an attempt to integrate medical rehabilitation and the process of solving everyday problems—emotional and physical—which patients must meet once they have received maximum benefit from medical restoration. Evaluation will be concerned with functional performance of the patients in the program and in the attitudes toward working with the disabled.

PHS region	Project No.	Grantee and project director	Period	Amount
National	CH-55-4-A-62 CH-55-4-B-63 CH-55-4-C-64	Group Health Association of America, Inc., Washington, D.C.; W. Palmer Dearing, M.D.	June 15, 1962, to June 14, 1963-- June 15, 1963, to June 14, 1964-- June 15, 1964, to June 14, 1965--	\$62,300 73,034 76,700

This project is directed to collecting, analyzing, and disseminating nationwide basic medical care statistics on prepaid group practice programs. Such data will aid in planning and evaluating program operations. Uniform medical care statistics will also provide a basis for sound planning by labor and other consumer groups, community and professional groups, health institutions and government, which desire to establish comprehensive health-care programs. Standards and methods will be developed for regular collection, analysis, and dissemination of statistical data.

X. SURVEYS OF HEALTH NEEDS, FACILITIES, OR PROBLEMS

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-28-A-63	Health Research, Inc., Albany, N.Y.; David B. Ast, D.D.S.	July 1, 1963, to June 30, 1965 (1 year only).	\$18,086

This project will determine the actual prevalence of physical handicapping malocclusion among 12-16 year-old schoolchildren in upstate New York, using a stratified sampling already prepared, and will, as a second objective, refine the HLD index as an objective tool to determine severity of malocclusion. As a result of the refinement of the index, preliminary screening can be performed by clerks, rather than dentists, which will result in lower cost.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-41-A-64	Medical & Health Research Association of New York City, Inc., New York, N.Y.; Lester J. Rosner, M.A., LL.B.	Apr. 1, 1964, to Mar. 31, 1965-- Tentative-----	\$43,465 37,759 27,463

The primary purpose of this project is to develop a school health team which will employ an optimum percentage of professional time for professional purposes. It will also develop methodology for studying public health personnel utilization patterns. It will be conducted in three phases. Phase I will be a utilization study of the present system of staffing. Phase II will be an analysis of the base-line data and experimentation with restructured staffing patterns, and phase III will be an appraisal of the restructured patterns.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-36-A-63 CH-40-36-B-64	Philadelphia Health Re- search Fund, Philadelphia, Pa.; David A. Soricelli, D.D.S., M.P.H.	May 1, 1963, to Apr. 30, 1964-- May 1, 1964, to Apr. 30, 1965-- Tentative-----	\$30,748 36,715 33,620

A project to determine how the dental needs of the chronically ill homebound patient can best be met. A representative sample of homebound patients will be made and a complete dental examination given to every patient included in the sample. Operative, surgical, prosthetic, periodontal and oral hygiene care will be provided as indicated. Experience gained through providing treatment will hopefully spell out factors influencing decisionmaking criteria in this area. The study will be a joint project of the Division of Dental Health of the Philadelphia Department of Public Health and the Philadelphia County Dental Society.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-27-6-A-63 CH-27-6-B-64	Missouri State Division of Health, Jefferson City, Mo.; Dr. D. W. Bryant.	Apr. 1, 1963, to Mar. 31, 1964-- Apr. 1, 1964, to Aug. 31, 1965 (2 years only).	\$29,215 30,990

This project is a methodological study of mechanisms for collecting morbidity data from private physicians on a regular basis in an attempt to determine the extent to which valid and reliable data can be secured in this way, and the method which is best. Samplings of general practitioners, internists, pediatricians, and specialists will be selected and three methods of securing data will be tried. For one group of doctors, arrangements will be made to pay their nurses for recording the information; a second group will be asked to forward the names of patients and the study nurse will extract the necessary data from the doctor's records; and a third group will be asked to dictate the data to their secretaries who will forward the material to the study center. The reliability of the reporting will be assessed by comparing reports with physician records.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH-39-1-A-62	Yamhill County Health Department, McMinnville, Oreg.; Elton Kessel, M.D., M.P.H.	July 1, 1962, to June 30, 1963---	\$31,550
	CH-39-1-B-63		July 1, 1963, to June 30, 1964---	22,010
	CH-39-1-C-64		July 1, 1964, to June 30, 1965---	15,979

The purpose of this project is the establishment on a demonstrative basis of a senior citizens' center by a county health department which serves a small town in a rural area where home health services are limited. The functions of the center are to include periodic health appraisal and maintenance, with home nursing and homemaker services. In addition, recreational and social activities are to be provided.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH-13-5-A-64	Hawaii State Department of Health, Honolulu, Hawaii; Paul T. Bruyere, M.D.	Dec. 1, 1963, to Nov. 30, 1964..	\$15,110
	CH-13-5-B-65		Dec. 1, 1964, to Nov. 30, 1965..	20,023
			Tentative-----	20,828

The objective of this project is health surveillance, by means of continuing monthly household interviews, to provide information needed in planning and evaluating health programs. Public health nurses will question a random sample of residents of Oahu Island to provide sensitive, up-to-date measures of morbidity, population characteristics, health attitudes and information in the community. A record will be kept of how and to what extent survey results are used by units of the health department as well as by outside agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
National	CH-55-2-A-62	American Public Health Association, New York, N.Y.; Dean W. Roberts, M.D.	July 1, 1962, to June 30, 1966---	\$400,000
	Supplement A-65			91,553
			Tentative-----	100,861

Funds have been made available to support the collection and study of facts about community health needs and practices and to promote the translation of this knowledge into effective community health services, particularly those needed by the chronically ill and aged. Through the establishment of a National Commission on Community Health Services, it is expected to define the characteristics and assess the current status of community health services and establish goals for strengthening, extending, and improving such services. In addition, attention will be directed to developing principles of organization and action for health agencies as well as standards for community health services and to focusing public attention on the goals established and plans for action.

XI. EVALUATION OF SPECIFIC TREATMENT PRACTICES OR TECHNIQUES

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-07-13-A-65	Hartford Hospital, Hartford, Conn.; Ralph F. Reinfrank, M.D.	Feb. 1, 1965, to Jan. 31, 1966--- Tentative-----	\$31,144 21,273

This project will demonstrate within the setting of a large community hospital the application of recent advances in the automatic analysis and processing of electrocardiograms. Automatic EKG procedures will be introduced into the routine outpatient and emergency room services of the Hartford Hospital and results will be recorded on FM magnetic tape and transmitted over ordinary telephone lines to the cooperating computer center in Washington, D.C., where they will be interpreted. Diagnoses will be either mailed back or can be teletyped back within minutes after receipt of the tracings. Appropriate quality control studies documenting the accuracy of computed diagnoses will be conducted.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH-23-6-A-63 CH-23-6-B-64 CH-23-6-C-65	Age Center of New England, Inc., Boston, Mass.; Hugh Cabot.	Nov. 1, 1962, to Oct. 31, 1963--- Nov. 1, 1963, to Oct. 31, 1964--- Nov. 1, 1964, to Oct. 31, 1965---	\$108,917 131,789 131,667

The main objective of this project is to test the interrelations of health and social dependency in people 65 or over and to study a method of dependency prevention in a random, stratified urban sample. The Age Center of New England, in a 7-year research study on over 1,000 older men and women, has developed a method for the prevention of dependency in later years. This study will attempt to determine in detail the degree to which the method can be fully effective in another urban area. Through an interviewing and counseling program by trained staff, the study will introduce intervention in an attempt to reverse the trend toward illness and social dependency in late age by modifying older people's perception and understanding of their own aging and evaluating carefully the social and health changes which occur after a year has elapsed. It is the intent of the study to test and document the age center method of dependency prevention to the point where it can be introduced to health and social agencies as a tool in their ongoing work.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-35-A-64 CH-34-35-B-65	St. Luke's Hospital, New York, N.Y.; Dr. Theodore Van Itallie.	Jan. 1, 1964, to Dec. 31, 1964--- Jan. 1, 1965, to Dec. 31, 1965--- Tentative-----	\$30,051 33,606 25,551

This project is directed toward the control of recurrence of the symptoms of congestive heart failure through the use of para-medical personnel at the community level. It will incorporate comprehensive medical care in the clinic, home visits by Public Health nurses, dietary counseling and social service assistance as needed. It hopes to demonstrate that the addition of close supervision of congestive heart failure patients in the home can reduce the recurrence rate and readmission rate to the hospital by 50 percent.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-40-46-A-64	Pennsylvania State College of Optometry, Philadelphia, Pa.; William G. Walton, Jr., O.D.	Apr. 1, 1964, to Mar. 31, 1965 (1 year only).	\$11,691

The sponsor will conduct a multiphasic investigation of the visual problems of institutionalized out-of-hospital aged in an attempt to develop improved and more efficient visual care programs. The study will concern itself with (1) examination of aged patients, (2) study of the adaptation of examining procedures to the unique visual problems of the aged, (3) demonstration and study of the benefits to aged patients of optometric services, and (4) standardization of criteria for referral of patients for medical care. Data collected will be continuously studied and analyzed and periodic reports prepared.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-09-4-A-63 CH-09-4-B-64 CH-09-4-C-65	District of Columbia Tuberculosis Association and District of Columbia Department of Public Health, Washington, D.C.; William Becque.	Oct. 1, 1962, to Sept. 30, 1963--- Oct. 1, 1963, to Sept. 30, 1964--- Oct. 1, 1964, to Sept. 30, 1965---	\$13,816 27,848 32,154

The objectives of this project are to diagnose the alcoholism of individuals with tuberculosis and to supply continuing treatment for alcoholic tubercular patients on an outpatient basis. Patients at Glenn Dale Hospital with possible diagnosis of alcoholism are now referred to the alcohol rehabilitation center during their treatment for tuberculosis. Funds are requested in this project for the hiring of a psychiatric social worker who will serve on a full-time basis with the Alcoholic Rehabilitation Division of the District of Columbia Department of Public Health and as liaison between the division's clinic staff and the staff at Glenn Dale Hospital. Treatment of both tuberculosis and alcoholism will be continued on an outpatient basis after the patient's release from Glenn Dale. It is expected that a wealth of clinical data will be accumulated which will provide a basis for subsequent research.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-19-3-A-64	University of Kentucky, Lexington, Ky.; Kurt W. Deuschle, M.D., Sylvester A. Shaffer, M.D.	Mar. 1, 1964, to Feb. 28, 1965 (1 year only).	\$86,286

The major objective of this project is to demonstrate how a tuberculosis eradication program can be established and carried out in a rural Appalachian county of eastern Kentucky, using the program as an initial technique to win family acceptance, to be followed by delivery of comprehensive health services. Although the demonstration is built around tuberculosis, it will be a prototype for the development of a comprehensive out-of-hospital service program for a rural, depressed area.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-19-9-A-65	Lynch Medical Services, Harlan, Ky.; Beatrice Elrod Cope, R.N.	Dec. 1, 1964, to Nov. 30, 1965-- Tentative-----	\$18,435 17,985 17,485

This project will demonstrate maximum utilization of scarce health manpower in an Appalachian coal mining community. It expects to stimulate the adult community, particularly the parents of preschool and school-age children, to take a positive interest in basic oral hygiene and dental health in behalf of their children. Demonstration of incremental dental care services and a planned program of oral hygiene education for students of the Lynch Independent School District, Harlan County, Ky., is expected to raise the health standards, educational achievements, and economic opportunities of the residents of an economically depressed coal-mining town in Appalachia.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-35-6-A-63 CH-35-6-B-64	Duke University Medical Center, Durham, N.C.; Morton D. Bogdonoff, M.D.	July 1, 1963, to Sept. 30, 1964... Oct. 1, 1964, to Sept. 30, 1965... Tentative-----	\$94,309 102,535 112,326

This project is designed to evaluate a specific type of health care management—termed the health team approach—upon the health status and course of ambulatory patients with chronic illness. This approach is characterized by continuity of care, planned assessment of the patient's feelings and attitudes and their specific utilization during long-term care, and expanded and more singular roles of activity for the allied health care personnel. The characteristics of the patient's course and health status will be evaluated through study of symptomatic response, physiologic response, and functional role change.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-49-2-A-62	Bureau of Public Health, Lynchburg, Va.; John T. T. Hundley, M.D.	July 1, 1962, to June 30, 1963 (project canceled and funds returned to PHS).	\$11,360

Funds have been made available to the bureau of health to test and demonstrate new and comprehensive program of out-of-hospital services coordinated with inpatient services, using the resources of a uniquely combined local health and welfare department. A chronic disease evaluation and treatment clinic will be established, with follow-up services to assure adequate care is maintained, to provide social services, and to determine final disposition of the patient.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH-52-9-A-64 CH-52-9-B-65	Lawrence Frankel Foundation, Inc., Charleston, W. Va.; Willard Pushkin, M.D.	Nov. 15, 1964, to Nov. 14, 1965.. Nov. 15, 1964, to Mar. 31, 1965..	\$54,000 12,000

This project will assess the effect of a supervised and graded physical exercise program as a therapeutic device for patients with coronary heart disease to determine (1) its feasibility, (2) the rehabilitative effect of the exercise, (3) the capacity of a continued conditioning exercise program for maintaining physical and vocational fitness, and (4) the prophylactic efficacy on the natural course of the disease following its stabilization. Two groups of at least 100 patients each will be used, one as a control group. Evaluation will also be made of physician participation in such a community-oriented project.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-01-4-A-65	Alabama Tuberculosis Association, Birmingham, Ala.; K. W. Grinnley, George A. Danison, M.D.	Nov. 16, 1964, to Nov. 15, 1965.. Tentative-----	\$113,524 { 91,080 63,178

This project will conduct on a demonstration basis throughout the State of Alabama a program of case finding, case supervision, physical restoration and therapy and vocational rehabilitation where indicated, for victims of chronic pulmonary diseases. Operations will include first a survey unit for preliminary screening of individuals, and a second unit which will consist of a field laboratory to provide both confirmatory tests for diagnosis as well as for continuing follow-up of patients during their course of treatment.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-11-6-A-64 CH-11-6-B-65	Georgia Department of Public Health, Atlanta, Ga.; Joseph A. Wilber, M.D.	Jan. 1, 1964, to Dec. 31, 1964 --- Jan. 1, 1965, to Dec. 31, 1965---	\$11,821 16,262

The objective of this project is to define and delineate those areas and techniques whereby public health agencies can contribute to the management of hypertensive patients on a community basis. Patients who have been identified as hypertensives will be divided into two groups, the first to be offered an intensive 2-year program of medical education regarding hypertensive disease, with facilities available for the treatment of indigent patients free of charge. The second group will serve as a control group. At the end of 2 years both groups will be resurveyed and compared.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-45-3-A-64	University of Tennessee, Memphis, Tenn.; L. W. Diggs, M.D.	May 1, 1964, to Apr. 30, 1965-- Tentative-----	\$7,474 7,622 7,770

This project is concerned with the home study and care of sickle cell disease. The present knowledge concerning it has been obtained from patients in a hospital environment. The project will assign a full-time experienced registered nurse to periodically visit selected families with sickle cell disease in their homes. This nurse will serve as a liaison between the patient in the home and the "sickle cell center" at the university where basic and clinical research on hospital patients is in progress. It is hoped that the home study of patients in painful crises will furnish information regarding trigger mechanisms, seasonal incidence, manner of onset, location and migration of pain, periodicity, duration, variability in severity, association with infections, exanthema, weather and barometric conditions. Home remedies and experimental drugs will be tested. Normal individuals and those with sickle cell trait will serve as controls.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-12-A-63	Public Health Federation of the Cincinnati Area, Cincinnati, Ohio; Sewall O. Milliken.	June 1, 1963, to May 31, 1966 (full funded).	\$96,885

This project will develop, test and evaluate criteria of effective utilization of community health services serving the chronically ill, including criteria useful to the private physician, to a coordinated home care project, to a health department, to a visiting nurse association, and to an information and referral service, in planning comprehensive care and continuity of care for chronic illness patients. It will identify present patterns of utilization of current services, and attempt to improve these patterns through use of the criteria developed, tested and evaluated in the project.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-25-14-A-65	Mount Sinai Hospital, Minneapolis, Minn.; Jerome T. Grismer, M.D.	Nov. 1, 1964, to Oct. 31, 1965--- Tentative-----	\$70,340 70,635 72,071

This project will establish in the community a diagnostic unit which will perform comprehensive clinical physiologic tests of the cardiovascular and pulmonary systems either individually or simultaneously. The unit will provide easily available consultative service for private physicians, laymen, industrial

physicians and community agencies interested in the prevention, diagnosis, treatment and rehabilitation of cardiopulmonary disease.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH-27-16-A-63 CH-27-16-B-64	Jewish Hospital of St. Louis, St. Louis, Mo.; Franz U. Steinberg, M.D.	Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965... Tentative.....	\$31,663 29,833 29,833

The need for a liaison unit between hospital and home for congestive heart failure patients has been demonstrated by patients who respond to rest and medical treatment during their hospital stay but return to failure when they go back to their homes inadequately prepared for the physical exertions and emotional tensions which are part of their daily living. The grantee will establish such a unit for the rehabilitation of such patients. This unit will be part of the hospital's department of rehabilitation and chronic disease where patients can be hospitalized as long as necessary, and in it will be graduated from almost complete rest to increasing activities, using specialized clinical observations and calorie expenditure tests as a guide. Evaluation will be made using a control group and comparing number of readmissions to the hospital, total number of days spent in the hospital during these readmissions, and number of days of incapacity and/or loss of work.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH-04-3-A-64	Arkansas State Board of Health, Little Rock, Ark.; Bryant S. Swindoll, M.D.	Feb. 1, 1964, to Jan. 31, 1965 (1 year only).	\$13,758

Two nursing homes in Arkansas will (1) determine through laboratory tests the durability and flame retardancy of wearing apparel, bedclothing, and decorator fabrics after normal usage and washing, (2) compare the wearing qualities and service life of the articles with and without fire retardant properties, (3) determine the esthetic acceptability of articles which are fire retardant, and (4) obtain medical observation as to dermatological acceptability of flame retardant materials.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-1-A-62 CH-05-1-B-63 CH-05-1-C-64	California Medical Education & Research Foundation, San Francisco, Calif.; Murray Klutch.	June 1, 1962, to May 31, 1963... June 1, 1963, to May 31, 1964... June 1, 1964, to May 31, 1965...	\$14,700 26,131 43,113

The purpose of this project is to develop and test a number of methods and techniques by which local medical societies throughout the State of California can establish and maintain a continuous form of evaluation of services, primarily out of hospital, rendered by physicians in private practice. The sponsor is an operating arm of the California Medical Society. The first phase of the project involves a conference with leading representatives of all county medical societies for a 1-day presentation, discussion, and workshop centered around four experts in the field. Following this, meetings are planned with at least 10 medical societies interested in developing programs of evaluation, assisting them in initiating such a program and in conducting pilot tests of procedures developed. Subsequent evaluation of the several types of programs initiated will enable the sponsor to recommend adoption of one or more types to all county medical societies for continuing use after the 3-year project has been completed.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH-51-8-A-64	Lee House for Senior Citizens, Inc., Seattle, Wash.; Lorena Peterson.	July 1, 1964, to June 30, 1965--- Tentative-----	\$37,531 39,175 41,053

The objectives of this project are to identify the physical, social, and related health needs of senior citizens who come to a traditional-type day center, develop a diagnostic method for evaluating these needs, and develop a method for determining the effectiveness of a nurse-social work team approach in meeting them. The first phase of the study will develop procedures, the second will be concerned with the collection of data, and the third will evaluate it. It is anticipated that the findings of this study will make a significant contribution to others planning day centers for older citizens.

XII. SCREENING

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH-34-49-A-65	Buffalo & Erie County Tuberculosis & Health Association, Inc., Buffalo, N.Y.; V. J. Sallak, Ed. D.	Nov. 1, 1964, to Oct. 31, 1965-- Tentative-----	\$79,300 72,100 57,100

The objective of this project is the demonstration of community services to identify chronic respiratory disease, to provide diagnostic facilities and to direct patients for adequate medical care. It will use mobile clinic facilities to screen approximately 15,000 apparently healthy adults annually to find chronic respiratory abnormalities. Subjects with significant respiratory disease will be referred to their private physicians or to other treatment facilities.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH-09-1-A-62 CH-09-1-B-63 CH-09-1-C-64	Howard University, Washington, D.C.; Dorothy D. Watts, R.N., M.P.H.	May 15, 1962, to May 14, 1963-- May 15, 1963, to June 14, 1964-- May 15, 1964, to May 14, 1965--	\$24,954 38,823 41,868

The project will demonstrate the use of trained lay volunteers for door-to-door health and social problem screening in a lower class neighborhood. Individuals in need of services are brought to a health center for intensive diagnosis and for coordinated social casework and medical treatment. The sponsor will work toward improving physician-patient relationships in a coordinated service for low-income groups and explore the possibility of organizing and using the resources of physicians in the area for more preventive medical services.

PHS Region	Project No.	Grantee and project director	Period	Amount
V.....	CH-37-9-A-63	Western Reserve University, Cleveland, Ohio; Jack R. Leonards, M.D.	Oct. 15, 1962, to Oct. 14, 1963-- (1 year only).	\$34,582

The sponsor proposes to develop an accurate method of utilizing finger blood as a method of mass screening for diabetes, to test this method as a more effective technique for community screening for the early detection of diabetes by pilot studies, and to evaluate the use of such a method for widespread diabetes detection in an urban community. A mobile trailer unit is being used for the study. Support is given for only the first phase of the study.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-37-16-A-64 CH-37-16-B-65	Western Reserve University, Cleveland, Ohio; Gerald T. Kent, M.D., Jack R. Leon- ards, M.D.	Oct. 1, 1963, to Dec. 31, 1964... Jan. 1, 1965 to Dec. 31, 1965... Tentative.....	\$125,718 105,764 109,192

This is a continuation of the pilot study of finger blood as a method of mass screening for diabetes. (See project CH 37-9 A-63.) The sponsor has developed a new technique which has been used successfully in testing personnel on a community basis in a mobile unit and personnel of industrial plants. It is now planned to carry this method into the entire community, an area with a total population of 1,800,000 people. Funds were also requested for development of a new type of automatic glucose analyzer, but were not approved in the current award.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-8-A-63 CH-05-8-B-64 CH-05-8-C-65	Kaiser Foundation Research Institute, Oakland, Calif.; Morris F. Collen, M.D.	Sept. 1, 1962, to Aug. 31, 1963... Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965...	\$224,267 301,087 364,088

This project is designed to evaluate the effectiveness of multiphasic screening and to develop automated screening techniques, machine diagnostic techniques, and a framework for research in medical care. It is expected that the project will demonstrate how improved, automated techniques will effectively and economically furnish periodic health appraisals to large numbers of individuals. The computer storage of data on over 25,000 adults annually will permit extensive epidemiological research especially directed toward the preventive aspects of chronic disease. Plans call for development of refined and improved methods of procedure during the first year, the installation and operation of an expanded program in enlarged facilities during the second year, and the further accrual of research data and beginning of statistical analyses in the third year.

XIII. OTHER

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH-34-44-A-65	State University of New York, Albany, N.Y.; Eli A. Friedman, M.D.	Sept. 1, 1964, to Aug. 31, 1965... Tentative.....	\$191,954 202,288 203,929

Patients suffering end-stage renal failure due to a variety of diseases will be subjected to chronic peritoneal and hemodialysis in order to study the relative efficacy of these two approaches to chronic life prolongation.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH-01-3-A-65	University of Alabama Medi- cal Center, Birmingham, Ala.; H. Walker Brown.	Dec. 1, 1964, to Nov. 30, 1965... Tentative.....	\$211,509 177,486 191,420

This project will initiate a 5-bed, 15-patient intermittent dialysis facility in a well-controlled environment (the university medical center) in order to attempt to duplicate the success of the Seattle project, which other competent investigators using similar techniques have failed to do. It will investigate methods of improving the technique and initiate a comprehensive study of the effects of prolonged intermittent dialysis on the patient.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH-24-6-A-63 CH-24-6-B-64	Saginaw County Hospital, Saginaw, Mich., V. K. Volk, M.D.	June 1, 1963 to May 31, 1964---- June 1, 1964 to May 31, 1965--- Tentative-----	\$65,439 80,287 51,057

This project will establish and evaluate a day-care rehabilitation program in which out-of-hospital patients will receive medical and allied services at the hospital by being brought daily, or as necessary, by bus. Evaluation will seek to establish that such a program will reduce the hospital stay and insure continuity of care and that it will reduce readmissions and lower the overall cost of care of the long-term patients. Research in the project will be administered through the University of Michigan.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-2-A-62 CH-05-2-B-63	University of Southern California, Los Angeles, Calif.; Frederick J. Moore, M.D.	July 1, 1962 to June 30, 1963... July 1, 1963 to Jan 31, 1964 (2 years only).	\$134,179 50,626

Through this project the records systems of certain health and welfare agencies in the Los Angeles region will be automated with a view toward coordinating these and other systems in a central records index. The coordinated electronic central file is to service the needs of health practice, research, and teaching. Identity files are to be mechanized from the county general hospital and Bureau of Public Assistance as well as major districts of the county health department, units of the bureau of hospitals, and the Los Angeles District Office of Vocational Rehabilitation Services. Preliminary work has been done as a basis for the mechanization of these records. Grant funds will aid in the actual development of the center for the storage and retrieval of personal health information data.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-05-20-A-63	University of California, Los Angeles, Calif.; Olive G. Johnson.	Apr. 1, 1963, to Aug. 31, 1965 (full funded).	\$47,225

This project will make a study of the need for records and reports in local health departments for patient service and for planning and evaluating programs. It will appraise existing records and reports in relation to stated needs and current usage, and it will design systems for recording, processing, and maintenance that will assure availability of required data. It will also study the application of high-speed data processing to health department records.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-13-6-A-64	State Department of Health, Honolulu, Hawaii; Paul T. Bruyere, M.D.	Aug. 1, 1964 to July 31, 1967 (full funded).	\$50,355

The major purpose of the project will be to provide a thorough 55-year record and analysis of the mortality experience of the major ethnic groups in Hawaii as a guide in public health practice and research. Major emphasis will be on causes of death. A sample of Hawaii death records from 1908-62 will be coded, punched, tabulated, and analyzed to delineate differences in causes of death and trends among the various ethnic groups of Hawaii. Such data will aid health agencies in program planning and supply the bases for epidemiological and genetics research, and will also add materially to the demographic history of Hawaii's ethnic groups.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH-51-6-A-63	Seattle Artificial Kidney Center, Seattle, Wash.; John S. Murray, M.D.	July 1, 1963 to June 30, 1966, (full funded).	\$307,271

This project will enlarge the current 3-bed center to a 10-bed facility to reduce and study the costs of the treatment of patients with chronic uremia by periodic hemodialysis. It will demonstrate that this form of treatment is worthy of community support, and will work out with appropriate agencies in the area a pattern of long-term community support which will include a method of determining what each patient's own contribution should be. The facility will also be used for demonstration and training purposes for groups from other communities who plan similar facilities.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH-55-12-A-64	American Public Health Association, New York, N.Y.; Henrik L. Blum, M.D.	Feb. 1, 1964 to Jan. 31, 1965 (one year only).	\$23,249

This project will develop and publish a handbook which will describe in detail the major concepts of the public health approaches to control of chronic disease, including a detailed presentation of information about specific diseases, assembled for ready reference. Part I of the book will be devoted to major concepts of the public health approaches to control of chronic disease; Part II more detailed presentation of information about specific diseases. Utilization will be promoted through the channels of the APHA.

Dr. DEMPSEY. I would like to turn now to H.R. 2987, the group practices facilities bill. The President stated in his health message of January 7, 1965:

New approaches are needed to stretch the supply of medical specialists and to provide a wider range of medical services in the communities. The growth of voluntary, comprehensive group practice programs has demonstrated the feasibility of grouping health services for the mutual benefit of physicians and patients by—

Integrating the burgeoning medical specialties into an efficient and economical system of patient care.

Reducing the incidence of hospitalization which may now occur because there are few alternative centers for specialized care.

The initial capital requirements for group practice are substantial, and the funds are not now sufficiently available to stimulate the expansion and establishment of group practice. To facilitate and encourage this desirable trend, I recommend legislation to authorize a program of direct loans and loan guarantees to assist voluntary associations in the construction and equipping of facilities for comprehensive group practice.

The bill under consideration is designed to carry out the President's recommendation. Simply stated, it would authorize the Surgeon General to insure mortgages secured for the purpose of financing the construction costs of group practice facilities. It would also authorize the Surgeon General to make direct loans to group practice organizations to assist in financing the construction costs of group practice facilities.

Such loans would only be made if the Surgeon General finds that the applicant is responsible and able to repay the loan but is unable to secure the amount thereof from other sources upon terms and conditions applicable to the loans secured by mortgages insured by the Surgeon General.

At the same time that we increase the number of physicians and dentists under the provisions of the Health Professions Educational Assistance Act (Public Law 88-129), we should take steps to encourage their better distribution.

Also, we must stimulate the construction of facilities and the association of professional personnel in a manner that will be conducive to the most effective use of professional health personnel now available. Experience has demonstrated the advantages, both to patients and doctors, of general practitioners and specialists combining their diverse professional skills and using common facilities and personnel in providing medical and dental care by group practice.

In an era of specialization, group practice is the natural fulfillment of the need to bring diverse professional skills together under one roof to really treat the whole patient.

Experience also demonstrates that most physicians and dentists, when selecting a community in which to practice, insist upon modern diagnostic equipment and services, and for this reason are attracted to our larger urban areas where these services are more readily available.

Providing these services in group facilities located in smaller communities will, therefore, make the practice of medicine and dentistry in such communities more attractive.

Yesterday the Secretary in his testimony emphasized that the provisions of the group practices bill would encourage the provision of better medical care in small communities into the United States.

The proposed mortgage insurance program, supplemented by loan authority, will stimulate organization of additional voluntary prepayment plans under which high-quality comprehensive medical or dental care, or both, is made available on a group practice basis at premium costs within the means of persons with moderate incomes.

Consumer groups wishing to organize such plans, instead of having to depend on extensive fund raising programs, in advance of enrollment of members in the plans, could, under the bill, borrow funds for capital outlay on terms that would permit them to repay the principal and interest out of current premiums.

One of the chief obstacles to the development of prepaid medical care plans and the group practice of medicine and dentistry is the difficulty in securing financing on reasonable terms to meet the cost of constructing facilities needed for group practice and the cost of providing the equipment needed for essential services, such as laboratory and X-ray service.

Federal insurance of mortgage loans should enable and encourage private lenders to provide sufficient funds to make possible the construction of group practice facilities in most communities.

However, because of the specialized nature of the facility and lack of experience with the financial risks involved, there may be some communities in which loans from private sources may not be available on any terms or may be available only on terms which discourage or prevent the groups concerned from undertaking the group practices venture; in such situations direct loan authority is needed to supplement the mortgage insurance authority. The proposed bill, by providing measures to help overcome these financial barriers, would stimulate the establishment of group practices facilities and give special priority to those located in smaller communities, and those sponsored by public or nonprofit organizations.

This bill calls for appropriations of up to \$10 million for the fiscal year 1966 to provide capital for the mortgage insurance and loan funds. The ceiling on appropriations authorized for this purpose would be increased by \$12,500,000 at the beginning of fiscal year 1967, and by a like amount at the beginning of each of the next 3 fiscal years, so that during the fifth year the aggregate appropriations authorized would be \$60 million.

It should be remembered however, that these funds will be used for direct loans and to cover any defaults that may occur early in the program. Premium charges on insured mortgages and direct loans will accumulate later on to cover defaults and the costs of operating the program.

Over a long period of time these funds will all be really repaid to the Treasury Department. In effect, the program is self-liquidating and would be operated at no cost to the taxpayer.

In summary, Mr. Chairman, we believe this bill will upgrade the quality of medical and dental care, accomplish a better distribution of physicians and dentists, reduce the hospital utilization rate, and stimulate the development of additional voluntary prepayment plans. These goals, I think you will agree, will contribute substantially to the health of our people.

I shall be glad to answer any questions you may have.

The CHAIRMAN. Thank you, Dr. Dempsey. We appreciate your very fine and concise statement on these highly important programs, and on the progress of our efforts toward the best possible health programs that we can obtain under our system.

Mr. Staggers, do you have any questions?

Mr. STAGGERS. Thank you, Mr. Chairman.

Your whole testimony is that these bills are designed to do away with the ills that confront and afflict mankind.

Dr. DEMPSEY. I believe so, sir.

Mr. STAGGERS. And to prolong the life of man. What is the longevity now of man and woman? Have you those figures?

Dr. DEMPSEY. 67 for men and 69 for women, I believe, are the current figures.

Mr. STAGGERS. I saw a prediction someplace that probably in the year 2000 we can expect that to be way up. I don't know whether you have information on that or not. That would be due to such programs as these, and research.

Dr. DEMPSEY. The progress now being made in the diseases characteristic of aging give some considerable hope, that the lifespan will be extended still further. I wouldn't want to guess what it will be by the year 2000, but I would certainly hope that it would be significantly greater than now.

Mr. STAGGERS. I saw a prediction somewhere that was fantastic to me as to what the life expectancy might be in the year 2000, but a lot of this hope is based upon bills such as these, research and advancement in the knowledge of diseases and attacking these diseases.

Dr. DEMPSEY. Development of research, which certainly will be furthered by the health research facilities bill as well as by features in the community health services bill, will produce information leading toward the prolongation of life and to the abolition of disease.

The reduction of disease by preventive measures and by therapeutic measures not only prolongs life directly, but it also makes life much

more enjoyable. So we are talking not only of an increasing life span, but an increase in an effective and enjoyable life span as well.

Mr. STAGGERS. Thank you very kindly, Doctor.

The CHAIRMAN. Doctor, how much in appropriations would H.R. 2984 authorize on an annual basis?

Dr. DEMPSEY. The health research facilities amendment? In the aggregate, \$400 million over the 5-year period.

The CHAIRMAN. \$400 million over a 5-year period?

Dr. DEMPSEY. Over a 5-year period; yes, sir.

Mr. BROYHILL. Will the gentleman yield?

Is that for just the first part of H.R. 2984? What about the second portion, the construction of specialized regional or national facilities?

Dr. DEMPSEY. Those were included in the overall total.

Mr. BROYHILL. Thank you.

The CHAIRMAN. In other words, the entire bill, H.R. 2984, would authorize \$400 million for a period of 5 years.

Dr. DEMPSEY. Yes, sir.

The CHAIRMAN. And does it provide a method of distribution on an annual basis, or is it equal for each year?

Dr. DEMPSEY. That is not provided for in the bill as it is written. The intent would be to have the larger appropriations of about \$80 million made during the first year—no, I am sorry—to have slightly larger than the average of \$80 million made during the first 2 years of the program as the regional centers are developed, and then to drop back to a somewhat smaller figure for the remaining years of the program.

In other words, the intent is not to use the \$400 million at the rate of \$80 million per year, but, rather, a slightly higher beginning rate, leveling off in the subsequent years.

The CHAIRMAN. Does the bill permit appropriations up to any amount within the 5-year period for any 1 year? In other words, is it flexible, so that more could be appropriated for the first year and less for the second and more for the third and less for the fourth, and so on?

Dr. DEMPSEY. So long as the aggregate did not exceed the \$400 million over the 5-year period; yes, sir.

The CHAIRMAN. Conceivably, could the entire \$400 million be appropriated the first year?

Dr. DEMPSEY. Conceivably. I can assure you that there is no such intent, however.

The CHAIRMAN. I am trying to find out exactly what is involved in the language. You know, there is an art to this matter, and I just wanted to know what you were proposing here in that regard.

Dr. DEMPSEY. What we were proposing was language which would permit the development of appropriation estimates year by year to meet the demands as they were seen in each year within the ceiling.

The CHAIRMAN. Within the \$400 million limitation?

Dr. DEMPSEY. Yes, sir.

The CHAIRMAN. What is budgeted for the first year?

Dr. DEMPSEY. My memory is that it is \$100 million.

No. In 1966 the current authorization still obtains.

The CHAIRMAN. What is the current authorization?

Dr. DEMPSEY. The current authorization is a total of \$50 million.

The CHAIRMAN. That is for the 1965 fiscal year?

Dr. DEMPSEY. Yes. And for fiscal year 1966, which is covered under the current authorization, it is also \$50 million. We are proposing in 1967 that this be increased to \$100 million, of which \$10 million would be put into the regional facilities.

The CHAIRMAN. 1967 would be what?

Dr. DEMPSEY. The total would be \$100 million.

The CHAIRMAN. And \$10 million would be for what?

Dr. DEMPSEY. The regional or national facilities.

The CHAIRMAN. Of course, that will not be budgeted until next year.

Dr. DEMPSEY. Yes, sir.

The CHAIRMAN. That is your intention.

Dr. DEMPSEY. Yes, sir.

Dr. TERRY. Mr. Chairman, I would like to explain that although this current authorization extends through the fiscal year 1966, at \$50 million, it is necessary for us to come in for extended authority because we will be unable to accept additional applications after June 30 this year.

The CHAIRMAN. Yes; I understand that.

These regional complexes that you are talking about are for research facilities, and that is an expansion of the present program?

Dr. DEMPSEY. Yes, sir. These would be laboratories devoted to such special subjects as aging, to regional laboratories for the provision of special animal resources, or national or regional toxicology and pharmacology installations. These are research installations proposed as an extension and expansion of the present program.

The CHAIRMAN. Would that include research efforts against heart disease, cancer, stroke, mental impairment, and so forth?

Dr. DEMPSEY. The proposed extension of the Health Research Facilities Construction Act will certainly contribute facilities for heart disease, cancer, and stroke research.

The CHAIRMAN. That is not a part of these hearings, though.

Dr. DEMPSEY. No.

The CHAIRMAN. I am talking about what is authorized here in that regard.

Dr. DEMPSEY. Some of the research that goes on in these facilities will obviously be related to these diseases, as well as to all other kinds of health research. This is not the major effort of the administration, to provide facilities for heart disease, cancer, and stroke. The relation of this to the other program is incidental.

The CHAIRMAN. Doctor, you have anticipated me, I think. But I was taking your own remarks on page 4 of your statement in which you describe the purpose of these research facilities that we are talking about. You did state what they were for. You included efforts against heart disease, cancer, stroke, mental impairment, and other major diseases.

Dr. DEMPSEY. Research directed toward these diseases would be carried out in these research facilities as they are now carried out in facilities built under the research construction authority.

The CHAIRMAN. As I say, you anticipated me. What I was going to follow on that with was that perhaps if this program was sufficient we would not necessarily have to enact the other proposal.

Dr. DEMPSEY. I hope to have an opportunity, Mr. Chairman, to explain at some future time why additional efforts toward these

major diseases will be necessary. I will be glad to elaborate on it now if you like.

The CHAIRMAN. No, I don't want to go into it now because it is a highly controversial question and subject. I hope when you have an opportunity in the future for elaborating or further explaining, you will also include why there is so much controversy over it.

Dr. DEMPSEY. I will do my best.

The CHAIRMAN. Mr. Springer?

Mr. SPRINGER. Doctor, you are a medical doctor?

Dr. DEMPSEY. No, sir; I am a Ph. D.

Mr. SPRINGER. In what field?

Dr. DEMPSEY. Biology.

Mr. SPRINGER. Do you know what an open-end authorization is?

Dr. DEMPSEY. Yes, sir.

Mr. SPRINGER. How many of these bills are open-end authorizations?

Dr. DEMPSEY. The community health services extension amendments are what I understand the term to apply to.

Mr. SPRINGER. Which bill are you referring to?

Dr. DEMPSEY. H.R. 2986.

Mr. SPRINGER. What about H.R. 2984?

Dr. DEMPSEY. H.R. 2984 has an appropriation ceiling over the 5-year period of \$400 million.

Mr. SPRINGER. I am reading from page 4, line 7:

There are hereby authorized to be appropriated for fiscal year ending June 30, 1966, and the 5 succeeding fiscal years, such sums as may be necessary for carrying out this section, and any sums appropriated for construction pursuant to this section shall be made available under this amendment.

Dr. DEMPSEY. This is the section pertaining to the construction of the specialized regional or national facilities. I am sorry; I wish to apologize to Mr. Broyhill on this.

I have had it pointed out to me that my answer to him was not correct. I had intended to pick up this point. I can, I believe, with respect to the question here.

There is, in addition to the \$400 million, an authorization for sums necessary to develop the regional and national centers. These are not included under the \$400 million, as I said previously. I apologize for my error. We are asking for authorization to develop this program, which is a new extension of the current construction program, for special purposes.

Mr. SPRINGER. You are talking about section 712; is that correct?

Dr. DEMPSEY. Yes, sir.

Mr. SPRINGER. That is an open-end authorization?

Dr. DEMPSEY. Yes, sir.

Mr. SPRINGER. But you are saying that to continue construction of health research facilities, that that is limited to \$400 million?

Dr. DEMPSEY. Yes, sir.

The CHAIRMAN. Would the gentleman yield at that point?

Mr. SPRINGER. Yes.

The CHAIRMAN. Did we not provide a regional complex for research in the last extension of this program?

Dr. TERRY. No, sir. As a matter of fact, Mr. Chairman, the authority which had been previously utilized, I believe it is paragraph

433(a) of the Public Health Service Act, for such regional facilities in the past was repealed by the Congress on last consideration.

The CHAIRMAN. Do you mean we did set up a regional complex some 3 or more years ago and then repealed it?

Dr. TERRY. No, sir. What I meant was this, Mr. Chairman: Over a period of years, through the Appropriations Committees, the Congress has made funds available for special projects, utilizing the authority in paragraph 433(a) of the Public Health Service Act.

When the Health Research Facilities Act was considered in 1961, this particular provision was repealed by the committee.

The CHAIRMAN. It is beginning to come back to me now.

Dr. TERRY. At the present time we do not have that basic authority.

The CHAIRMAN. But as I recall, Senator Hill on the Senate side put in a special provision for regional research centers. I think that was the reason that the committee repealed the provision you referred to, because the Appropriations Committees had been using that authority for purposes admittedly never intended.

I thought that we did, during the rearranging of that whole situation, provide some authority for a few regional complexes. I just remember that Senator Hill was tremendously concerned with that and there was something about it, something that I don't remember exactly right now.

Dr. TERRY. Basically, what it amounted to was that because of this disagreement, it was felt that this authorization which had been used previously should be deleted and that the Congress, and particularly this committee, would consider the matter further in terms of whether or not any type of authorization should be restored for such facilities.

The CHAIRMAN. I will not pursue it further at this moment, but I will review it.

Dr. DEMPSEY. Mr. Chairman, I have a quotation that bears on this with which I can clarify the situation now, if you would like.

The CHAIRMAN. I don't think I would like to take too much of the committee's time trying to recall for my memory what happened a few years ago, when so many of them were not here. It would be helpful to get it clarified.

Dr. DEMPSEY. I think I can state this in a short time. This authorization was requested in previous administration bills in the 87th and the 88th Congresses. H.R. 4999, as reported by the House committee, included this authority, but it died in 1962 when it was held up by the Rules Committee.

In 1963, this provision was eliminated by the House Interstate and Foreign Commerce Committee because "it felt that at this time it did not have available sufficient information which would have enabled the committee to pinpoint more specifically and circumscribe the rather broad scope of the authority which would have been granted to the Surgeon General under these rules."

The CHAIRMAN. Thank you very much.

Mr. SPRINGER. Doctor, let's turn to H.R. 2985. Is there any ceiling on grants under that bill?

Dr. DEMPSEY. This is the bill on staffing of mental health centers. May I ask Dr. Yolles to respond to that, as he and the Secretary testified on this bill yesterday?

The CHAIRMAN. Would you identify yourself?

Dr. YOLLES. I am Dr. Yolles, director of the National Institute of Mental Health.

H.R. 2985 is openended at the present time for such sums as may be appropriated by Congress.

Mr. SPRINGER. I would like to turn for a moment to H.R. 2987. Is this the first time that the Secretary has ever requested authority for such a program?

Dr. DEMPSEY. Yes, sir. May I correct that? This is the first time we have testified in support of such a program. It has been submitted to previous Congresses, but it has not been called up for hearings, I believe, sir.

Mr. SPRINGER. Has the Department presented a case for this before?

Dr. DEMPSEY. Not to committees; no.

Mr. SPRINGER. Not to any committee?

Dr. DEMPSEY. No, sir.

Mr. SPRINGER. Where does the interest come from for this bill? Somebody must have thought a good deal about it.

Dr. DEMPSEY. My own interest in it comes from the great concern that I have, and I believe this extends throughout the Department, in the increasing load upon our medical personnel that is caused by the increasing population and by its shift to cities.

The number of physicians being trained in the United States is not at the present time keeping pace with the expansion of the population. In order to continue to provide health care of the highest quality possible, we have to use, as efficiently as possible, the facilities and the resources and the personnel that we have available. There is very persuasive evidence that group practice is a more efficient way of delivering health care than is available otherwise. It is efficient both in terms of the increased number of patients that can be seen by individual physicians, and it is also efficient in the sense that the clientele of group practice is hospitalized less than is the case otherwise.

Mr. SPRINGER. Would you read the question back, Mr. Reporter? (The record was read by the reporter.)

Dr. DEMPSEY. I haven't really any other answer to it, Mr. Springer. I am not aware of any pressure that has been exerted to support the bill.

Mr. SPRINGER. Has any group, either in the health profession, the medical profession, the nursing profession, or anyone else who deals in this field, requested you for this authorization? If they have, would you name them?

Dr. DEMPSEY. I am not aware of any. I am not sure whether representations have been made to my predecessor, or to other people in the Department, but not to my knowledge; no, sir.

Mr. CARTER. Would the gentlemen yield?

Mr. SPRINGER. Yes.

Mr. CARTER. I think I am in a position to know, since I am a physician, that certainly my professional societies have not promulgated the particular bill.

Mr. SPRINGER. I thought that probably was true, but I was trying to find out if there was a demand for this where the demand was coming from, if it will produce better health care, and so forth, with this amendment; who says it will do this, besides you?

Dr. DEMPSEY. There is information and testimony available from organizations such as Group Health Association of America and others.

Mr. SPRINGER. Could you name an organization?

Dr. DEMPSEY. Yes, sir. The Group Health Association of America has made a spot check of the needs that their membership can project for facilities such as those suggested by the bill.

Mr. SPRINGER. Can you name another? Can you name one more?

Dr. DEMPSEY. Kaiser-Permanente Foundation is another one.

Mr. SPRINGER. Can you name someone else?

Dr. DEMPSEY. Group Health Insurance.

Mr. SPRINGER. Is that Blue Cross? Group Health Insurance I haven't heard of, but the other two I have. What do you mean by Group Health Insurance?

Dr. DEMPSEY. That is an organization. Another group you may have heard of is HIP: Health Insurance Plan of New York.

Mr. SPRINGER. Have they requested you to request this legislation?

Dr. DEMPSEY. No; not to my knowledge. They have provided evidence of the need for it.

Mr. SPRINGER. Have the other two organizations?

Dr. DEMPSEY. No, sir; not to me.

Mr. SPRINGER. I have been trying to make an inquiry in my own State. I haven't been able to locate anybody yet. I don't say there isn't anyone, but I haven't found anyone in the State of Illinois who requested this, or who believes this is what ought to be undertaken.

What I am trying, more or less, Doctor, to find out is whether or not there is real demand for it, or whether or not you are bringing it forward as the best idea that you have about it. This is what I am trying to find out.

Dr. DEMPSEY. To the best of my knowledge, it is a plan which we thought was an advisable one.

Mr. SPRINGER. In other words, this is your idea; is that right? You are presenting this as your idea?

Dr. DEMPSEY. As the Department's idea, and an administration proposal.

Mr. SPRINGER. I have a rural area, and you have talked about rural areas. I have had some demand, from more than one or two rural areas, where they couldn't get doctors unless they had a building there. The people raised the money themselves and built the building so that the doctors would move into the communities, but I haven't heard of any other demand, unless there is a demand from you as to what you believe ought to be done. That is my purpose in trying to make this record.

Dr. DEMPSEY. As I mentioned a moment ago, the Group Health Association of America has made a check, a rather quick one, of the construction needs among its membership, and estimates that they have need for borrowing more than \$15 million at the present time to meet their needs.

Mr. SPRINGER. What you mean is they would like to borrow; is that right?

Dr. DEMPSEY. Yes.

Mr. SPRINGER. Are these all M.D.'s who are interested in this?

Dr. DEMPSEY. Yes, sir.

Mr. SPRINGER. I don't know of any M.D. who isn't making enough money that they could go out and join forces and secure a loan and get started themselves on this.

Mr. HARVEY. Would the gentleman yield?

Mr. SPRINGER. Yes.

Mr. HARVEY. I wonder if the speaker would identify the Group Health Association. Is that an organization of M.D.'s or an organization of clinics?

Dr. TERRY. It is an organization of clinics. I can't tell you how many it consists of, but it is an organization of group practice type of organizations. I believe they are scheduled to testify before this committee tomorrow.

Mr. SPRINGER. If they are going to testify, I will put the questions to him.

Dr. TERRY. I am informed by Mr. Williamson that they will testify on Friday.

Mr. ROONEY. Mr. Springer, would you yield for a question?

Mr. SPRINGER. Yes.

Mr. ROONEY. Does this bill then put the Federal Government into the banking business, lending money to local organizations to build and develop these clinics?

Dr. DEMPSEY. It would guarantee loans made by local banks to these private groups. There is also a direct loan provision in the bill to be used in the event that mortgages cannot be arranged locally.

Mr. ROONEY. In other words, the Federal Government, then, is going into the banking business. They are taking the place of the banks in the local areas, instead of the banks lending the money to contractors or physicians who will develop these clinics. The Federal Government will come in.

Dr. DEMPSEY. No, sir. The banks will provide the mortgages wherever possible, but direct loans will be made only in the event that a direct loan is not available because there is not an adequate banking arrangement in the particular community.

Mr. ROONEY. Thank you.

Mr. SPRINGER. Doctor, may I ask you this: Are FHA loans available on this type of project?

Dr. DEMPSEY. No, sir.

Mr. SPRINGER. You are positive about that?

Dr. DEMPSEY. Yes, sir.

Mr. SPRINGER. I want to get this straight. Can the group practice unit or organization be an organization undertaking to provide comprehensive medical and dental care, which may include hospitals, to members on a prepayment group basis?

Dr. DEMPSEY. Yes.

Mr. SPRINGER. And the organization would then arrange with the medical group to provide the care?

Dr. DEMPSEY. Yes.

Mr. SPRINGER. Is that provided in this bill?

Dr. DEMPSEY. Yes.

Mr. SPRINGER. I take it, then, if you want to, you could get a business club in a community that could qualify, provided they could get the Secretary's approval, to set up an organization and hire a bunch of doctors and put them to work; is that correct? That is, nonprofit?

Dr. DEMPSEY. May I ask Dr. Graning to answer that?

Dr. GRANING. I am Dr. Harold Graning, Chief of the Division of Hospital and Medical Facilities, U.S. Public Health Service.

In listening to this discussion, I wonder if it would not be helpful to say that the concept of group practice has evolved in North America as in no place in the world. The American Medical Association, the American Association of Clinics, and the American Association of Clinic Managers have joined forces to provide guidelines to physicians who want to go into group practice.

Group practice is a very desirable way of making specialization workable and adaptable to total patient care. The reason for requesting mortgage insurance for the establishment of group practice facilities is that the cost involved in building facilities of this kind cannot be readily underwritten in a 10-year period insurance program.

This bill, which authorizes a program of mortgage insurance, would make it possible to underwrite the building costs over a 25-year period in most instances. This would, of course, mean that it is financially more attractive to form group practice. Group practice has made a substantial contribution to total patient care and it is today found throughout the length and breadth of our country with varying emphasis.

Some sections of the United States have substantial numbers of the populations served by group practice, and in other sections of the United States it has not caught on as much.

For instance, only 3.5 percent of the physicians in New England are engaged in group practice, whereas, about 12.2 percent are so engaged on the Pacific coast. In the West North-Central States, however, 22 percent of the physicians who are in practice are in group practice. As far as the distribution of groups is concerned 1.5 percent are in New England—15 percent on the west coast and 63.5 percent in the Central States.

Mr. SPRINGER. May I say I have two of the biggest ones in my community, but so far no one has asked me to see if I could get Federal money to expand them. Both of them were expanded several times since World War II, but no one has come to me saying that they needed to borrow from the Federal Government on a 25-year basis in order to expand.

But still, this question hasn't been answered yet: I asked whether or not a group practice unit or organization can be an organization, itself, undertaking to provide all this care, which may include hospitalization, to members on a group practice prepayment basis. That is what I asked.

Dr. GRANING. The matter of whether insurance is associated with group practice is really an independent question. A group of physicians would be the applicant for the funds. Relatively few of the men who are in group practice are actually involved in prepaid insurance programs.

Mr. SPRINGER. That is what I am trying to find out. There are only a few that are involved, but what you are attempting to do by this bill is to expand that group. Is that true or not?

Dr. GRANING. No, sir. As group practices are developed, it may be possible for people to enroll in prepayment plans for medical care and dental care. Independent plans may be developed by industry, or by selected groups that contract with a group of physicians who are going to provide medical care.

Mr. SPRINGER. At specified prices under a prepayment plan, is that correct?

Dr. GRANING. Yes, sir.

Mr. SPRINGER. That is what I am trying to find out.

Dr. GRANING. It may be so, sir; yes, sir.

Mr. SPRINGER. Then it would be possible if there was a business group or club in a community to set up its own organization, hire some doctors and put them to work; is that correct?

Dr. GRANING. The law provides that the Surgeon General would have the authority to decide whether this group met the standards of a group practice facilities as defined in the bill.

Mr. SPRINGER. I understand all that. But what I was trying to get at was whether or not this was one of the things that you were attempting to foster, a prepayment plan.

Dr. GRANING. This is certainly not the major focus of the bill. This would be an incidental development, but it is not the primary purpose of the legislation.

Mr. SPRINGER. Just one more question.

The CHAIRMAN. I am not satisfied either. What organizations are considered to be group practice units under your proposal? I think you ought to make it very clear, if you can.

Dr. GRANING. Group practice takes many forms. There are private multispecialty groups, mixed general practice groups, or single specialty groups. As far as this legislation is concerned they are any group of physicians who are organized to provide comprehensive care, using centralized records and centralized facilities, who could meet the Surgeon General's qualification as a group.

The CHAIRMAN. But you haven't made it clear whether these units or groups are limited to medical people.

Dr. GRANING. They are limited to medical people or dental people.

The CHAIRMAN. As I understood it, the Rotary Club could go out and organize a unit and put it into effect.

Mr. Moss. Will the gentleman yield for a moment? It seems to me on page 18, as I read it here, the term "medical or dental group" means a partnership or other association or group of persons licensed to practice medicine in the State, or persons licensed to practice dentistry in the State, or of both, who, as their principal professional activity, and as a group responsibility, engage or undertake to practice medicine cooperatively. Is this the type of group you are attempting to authorize here to go out and seek an insurance coverage for a mortgage received from a private banking or financing source?

Dr. GRANING. Yes, sir.

Mr. SPRINGER. Let's go a little further than this, since this is not quite as conclusive as Mr. Moss would say. Let's go to No. 4, on page 18:

The term "group practice unit or organization," (a) means a private agency or organization including a medical or dental group undertaking to provide directly or through arrangements with a medical or dental group comprehensive medical care or dental care or both which may include hospitalization to members or subscribers primarily on a group practice, prepayment basis, (b) a public or private nonprofit agency or organization established for the purpose of improving the availability of medical or dental care in the community or having some function or functions relating to the provision of such care which will, through lease or other arrangement, make the group practice facility with respect to which the mortgage insurance or loan has been requested under this title available to a medical or dental group for use by it, or (c) a medical or dental group.

That is not responsive to Mr. Moss' question, is it?

Mr. Moss. I think I am the best judge of the response to my question, Mr. Springer. My question was not intended to be inclusive of everything. I might say that there is a lot of discussion as to what was intended.

But it seems to that the definitions are included in the bill. That was the import of my question. So it was responsive, as far as Mr. Moss is concerned.

Mr. SPRINGER. We will admit, then, it was responsive to Mr. Moss. But I and the chairman have gained the impression that medical people were the ones who would be applicants for loans and they would be the only ones. I think there are three: A, B, and C. Is that correct?

Dr. GRANING. This is correct, sir. If there are any facets of this legislation that are not acceptable they could, of course, be deleted or changed. But the primary purpose of this legislation is to make it possible to extend the concept of group practice to some sections of the United States where groups are anxious to establish such a practice.

The CHAIRMAN. Will the gentleman yield?

Mr. SPRINGER. Yes.

The CHAIRMAN. Doctor, what we are trying to do is to find out what you mean and what you intend to do by this. We are talking about what is in the proposal. We know what you have said in your general explanation of it.

What we are trying to do is to analyze what you have in the bill and what it proposes. That is all we are trying to get. I think it would be very helpful if we could get precisely what it is.

Dr. DEMPSEY. Mr. Chairman, may I say that my understanding of this is that any of the three groups specified under A, B, and C, which Mr. Springer mentioned, could sponsor an application. A group of physicians or dentists being a medical group, or a private or non-profit agency, which obtains medical care through arrangements with a medical or dental group, could apply for assistance. Also, I believe, a public or private nonprofit agency could lease the facility to the group of doctors or dentists in the process of obtaining medical and dental care.

Mr. SPRINGER. Let's put this in simple form. First, a private agency or organization can do it.

Dr. DEMPSEY. Yes, sir,

Mr. SPRINGER. A private agency or organization which can get the approval of the Secretary can get this loan. If I want to set one of these up out in a town in my district, I could get a group of private citizens, couldn't I, to make this application?

Dr. DEMPSEY. Only if they were able to work out an agreement with the doctors and dentists who would provide care.

Mr. SPRINGER. All right. They can make a profit. I am talking about in A.

Dr. DEMPSEY. Yes, sir.

Mr. SPRINGER. This is not a nonprofit. This is a group that can set this up for profit.

Dr. GRANING. Yes, sir.

Mr. SPRINGER. Let's go on to B, a public or private nonprofit agency. It can be either one in that classification.

Dr. DEMPSEY. Yes, sir.

Mr. SPRINGER. And C, a medical or dental group. So we have the three groups and this is exactly who can apply for a loan?

Dr. DEMPSEY. Yes, sir.

Mr. SPRINGER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Friedel?

Mr. FRIEDEL. Dr. Dempsey, I want to compliment you on your very fine statement. As the chairman said, it is very complex. I have one question on page 13 of your statement that I would like to ask you.

You state:

However, the major purpose of the extended authorization is undertaking a nationwide program of immunization against the measles.

Has the vaccination for measles proved 100-percent perfect?

Dr. DEMPSEY. No, sir, I don't believe it is 100-percent perfect. But the effectiveness of the measles vaccines that have recently been developed have proved to be effective to over 90 percent.

Mr. FRIEDEL. Over 90 percent?

Dr. DEMPSEY. Yes, sir.

Mr. FRIEDEL. Then why are doctors lax in using this vaccination on children? That is if it is 90 percent effective.

Dr. DEMPSEY. There are two reasons, we believe. One of them is the relatively high cost of the vaccine at the present time. The second is that since this is newly available the public does not sufficiently appreciate that the vaccines now are available and are as effective as they are.

There is another factor that operates here. The public in general does not understand adequately, in my opinion, the seriousness of measles. It is regarded as a reasonably innocuous disease.

Yet the number of deaths and the damage to children which result from measles is much more serious than we believe the public actually appreciates.

Mr. FRIEDEL. In your statement, you said around 4 million cases of measles and around 500 deaths.

Dr. DEMPSEY. Yes.

Mr. FRIEDEL. I have not noticed anything in the press lately. I would think that it would be publicized much more widely, to get the parents to have their children vaccinated.

Dr. DEMPSEY. We are attempting to bring to the public the need for vaccination against measles, with every device that we know how to use, sir.

Mr. CARTER. Will the speaker yield?

Mr. FRIEDEL. I will yield.

Mr. CARTER. I think this is pretty well known. Doctors are pushing the immunization. We know it is effective. One thing is that the vaccine does cost a great deal, that is true. But even in Appalachia we are pushing it, to immunize a lot of children.

We realize the problems that measles cause. In the 28 years I have been a physician, I have seen some very dangerous cases. This can be a very serious disease. We are not going to be lax on pushing the immunization against the measles.

Thank you.

Mr. FRIEDEL. Thank you, Mr. Chairman. That is all.

The CHAIRMAN. Mr. Younger.

Mr. YOUNGER. Thank you, Mr. Chairman.

For the basis of some questions, I would like to read into the record section 202, demonstration health facilities of the Appalachian bill:

Section 202(a). In order to demonstrate the value of adequate health facilities to the economic development of the region, the Secretary of Health, Education, and Welfare is authorized to make grants for the construction, equipment, and operation of multicounty demonstration health facilities, including hospitals, regional health, diagnostic and treatment centers, and other facilities necessary to health.

Grants for such construction, including initial equipment, shall be made in accordance with the applicable provisions of title VI of the Public Health Service Act (42 U.S.C. 291 and 291(c)) and the Mental Retardation Facilities and Community Mental Health Center Construction Act, 1963 (77 Stat. 282) without regard to any provisions therein relating to appropriation authorization ceiling or to allotments among the States.

Grants under this section shall be made solely out of the funds appropriated for the purpose of carrying out this act and shall not be taken into account in the computation of the allotments among the States made pursuant to any other provision of law.

(b) No grant under the section for construction, including initial equipment, shall exceed 80 per centum of the cost of the project. Not to exceed \$41 million of the funds authorized in section 401 shall be available for construction grants under this section.

(c) Grants under this section for operation, including equipment other than initial equipment of a project, may be made up to 100 per centum of the cost thereof for a 2-year period beginning on the first day such project is in operation as a health facility.

For the next 3 years of operation, such grants shall not exceed 50 per centum of such cost. No grants for operation of a project shall be made after 5 years following the commencement of such operation, not to exceed \$28 million of the funds authorized in section 401 of the act, shall be available for operation grants under this section.

My first question is, are these figures in regard to the limitation on appropriation and other facilities recommended by the HEW?

Dr. DEMPSEY. Yes. We were consulted and were associated with the figures that were presented.

Mr. YOUNGER. All of this work to be constructed would be handled by HEW?

Dr. TERRY. This is my understanding from the reading of it; yes, sir.

Mr. YOUNGER. You are recommending here \$41 million for 1 year for 1 State and parts of 10 other States, as against \$50 million, as I understand the figures, for the whole 50 States. Is that correct?

Dr. TERRY. I think you will have to take into consideration that you are talking about two different things, Mr. Younger. We are talking about health research facilities when we speak of the \$50 million about which we are testifying today. The provision within the bill from which you are quoting would involve many other facilities which would fall under our Hill-Burton program and other related types of medical facilities.

Our ceiling of above \$200 million in the Hill-Burton program is more comparable to the Appalachian proposal than is the \$50 million authorized for the construction of research facilities.

Mr. YOUNGER. Would you recommend that in the counties of other States which have an equality of unemployment the same treatment that is given to this 1 State and parts of 10 others?

Dr. TERRY. It seems to me that such recommendation would be sound, sir.

Mr. YOUNGER. But you haven't made it in any of these bills.

Dr. TERRY. No, sir.

Mr. YOUNGER. For instance, in H.R. 2985, there the staffing and operation has 75-percent support for 15 months and in Appalachia it is 100 percent, including equipment.

Dr. TERRY. For the first year; yes, sir.

Mr. YOUNGER. No, 2 years.

Dr. TERRY. Two years; yes, sir.

Mr. YOUNGER. And then 50 percent after that. In your bill, you say 75 percent for 15 months, 60 percent for the next year, and then you drop down to 45, and 30 for the fourth year, 30 percent.

Dr. TERRY. This recommendation is specifically for mental health centers.

Mr. YOUNGER. But this is for the operation. This could also include the same kind for mental health centers under this bill. You could build the same facility under S. 3 that you can under H.R. 2985.

Dr. TERRY. That might possibly be true; yes, sir.

Mr. YOUNGER. It is an open end authorization of any kind of a health facility, virtually. Isn't that true?

Dr. TERRY. I believe so; yes, sir.

Mr. YOUNGER. Then why do you recommend a different treatment for one area as against another area where the same conditions exist as to poverty?

Dr. TERRY. I think, Mr. Younger, the thrust of the Appalachian bill is to give particular attention to an area where the need is greatest at this time.

Mr. YOUNGER. Do you think what you have recommended is sufficient for the Appalachia?

Dr. TERRY. What is in S. 3, do you mean?

Mr. YOUNGER. Yes.

Dr. TERRY. No; I am not sure that it is sufficient at all, but I think it would be a great help.

Mr. YOUNGER. Then you think on top of all of this we should add the other layer of icing that you are proposing in these other bills so that you can do the same thing that you can do in all the other States?

Dr. TERRY. I don't consider this icing, sir. I would call it plain bread, sir, the substance of life—not anything that is fancy.

Mr. YOUNGER. But you want another loaf of plain bread for this area as against any other area; is that correct?

Dr. TERRY. Yes, sir.

Mr. YOUNGER. You think that should be done?

Dr. TERRY. Where such need is evident; yes, sir.

Mr. YOUNGER. But not in the other States?

Dr. TERRY. I didn't say that. The thing I said, Mr. Younger, was this: I thought in the Appalachian bill we were trying to devote our attention to an area where the need is greatest. That doesn't mean that there are not other great needs.

Mr. YOUNGER. What I am trying to get at is if there are other great needs, why wasn't the recommendation made for the other great needs in the other States?

The CHAIRMAN. I think we ought to discuss these programs fully and completely, but we are talking about an entirely different program that does not come under the jurisdiction of this committee. This involves a matter that was reported from another committee altogether.

Mr. YOUNGER. I realize that, Mr. Chairman, but these are matters that come under the jurisdiction of the witness, and I would like to have him answer for the record.

The CHAIRMAN. He can answer only what he cares to answer insofar as the Appalachia bill is concerned. I understood that was an administration proposal. It went to another committee and did not come to this committee.

Mr. YOUNGER. That is correct, but it comes under the HEW, whose witnesses are here before us today.

Dr. TERRY. Mr. Chairman, I assure you that I have answered as completely and as fully as I have knowledge to answer.

The CHAIRMAN. All right.

Mr. YOUNGER. Now, to get back to the mortgage facility, you say you have never testified before on this proposal.

Dr. DEMPSEY. No, sir.

Mr. YOUNGER. Last year, in connection with the extension of Hill-Burton, which is known as the Public Health Service Act of 1964, under part B, "Mortgage insurance for construction and modernization of hospitals and other medical facilities," that was presented to the committee last year and the committee took it up. We had a discussion of it because it was in the bill last year. Were you here last year?

Dr. DEMPSEY. No, sir.

Mr. YOUNGER. It was a part of the extension of the Hill-Burton Act last year, which was H.R. 10041.

Dr. DEMPSEY. I was unaware of that. I apologize for my inadvertence. I believe that Hill-Burton proposal was for modernization of hospitals.

May I ask Dr. Graning to comment on this?

Dr. GRANING. The bill submitted by the administration was not the bill that was subsequently heard by this committee. The bill that was heard by the committee did, however, include the provision for mortgage insurance.

Mr. YOUNGER. This bill?

Dr. GRANING. It did include it; yes, sir.

Mr. YOUNGER. And we took section B out?

Dr. GRANING. Yes, sir; the bill that was heard by this committee did include it. You are quite right, sir.

Mr. YOUNGER. Are you sure, in your testimony, that there are no lending agencies now authorized to make loans on these buildings and facilities for group practice? As I understood your testimony, you say there are no available loans beyond 10 years for this kind of construction. I want to know if you are sure of that.

Dr. GRANING. Mr. Younger, groups have been able to get loans in excess of 10 years, depending upon their fiscal stability and their acceptance in the community. Loans from the Small Business Administration are limited to 10 years.

Mr. YOUNGER. Would you speak a little louder, please?

Dr. GRANING. Groups have been able to get some loans in excess of 10 years, depending upon their fiscal ability and their acceptance in the community. As indicated in earlier testimony, the value of the mortgage insurance program would be that it would be possible for beginning groups—who do not have substantial fiscal resources or who are not considered good risks—to get loans that could be amortized over a longer period of time.

Mr. YOUNGER. Then it is your proposal to insure poor risks?

Dr. GRANING. No, sir.

Mr. YOUNGER. You say that people who are good risks can get loans, but you want to insure the poor risks.

Dr. GRANING. The amount of money that would have to be repaid in a 10-year period——

Mr. YOUNGER. I am talking about longer periods. I am not positive of this myself, but I think any savings and loan association, either State or Federal, up to a certain percentage of their assets, and I think it is 10 percent, are authorized to make loans of this type for longer periods than 10 years, and possibly up to 25.

Dr. GRANING. You are undoubtedly correct.

The CHAIRMAN. Mr. Moss?

Mr. MOSS. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. I notice the language as to declaration of findings points out that group practice of medicine or dentistry offers great promise in improving the quality of medical and dental care. I am sure we would all agree with that. But I notice on page 2 that you state, "to a more effective distribution and utilization of physicians and dentists and other health service personnel in short supply, and of facilitating the establishment, operation, and expansion of voluntary prepayment plans offering comprehensive health service to their members or subscribers."

Do I understand this to mean that you can belong to this group and have a membership arrangement, and does this group then hire the physician and provide facilities and all these services? I am curious as to just what this means.

Dr. GRANING. As indicated earlier, one of the options under the bill would make it possible for a group to do so; yes, sir.

Mr. NELSEN. They can hire their physicians?

Dr. GRANING. The private group would have to include physicians.

Mr. NELSEN. And they may be the employee of the group? The physician may be the employee of the group?

Dr. GRANING. This is true, sir.

Mr. NELSEN. I notice further on page 2, and this refers to the interrogation of Mr. Springer earlier relative to who may be the group, one further point. I was led to believe that doctors could join together to provide this type of service, but I note the term "group practice unit or organization, particularly those in small communities and those sponsored by cooperatives and other nonprofit organizations."

I get the impression from reading this language that there is a little bit of a preference given to the nonprofit and cooperative, and the physicians would be secondary as to preference from the language in this paragraph.

Dr. GRANING. This is not the intent. If so, we——

Mr. NELSEN. Wouldn't you agree that that would be the impression you would get from reading the language?

Dr. GRANING. It could be the impression; yes, sir.

Mr. NELSEN. Thank you. I have no further questions.

The CHAIRMAN. Mr. Dingell?

Mr. DINGELL. Thank you, Mr. Chairman.

I am very interested in the provisions of H.R. 2984, providing for Assistant Secretaries in the Department of Health, Education, and

Welfare, and for other purposes. I wonder if you would tell us the duties of the present Assistant Secretaries for Health, Education, and Welfare. They are three in number, are they not?

Dr. DEMPSEY. Yes, sir.

Mr. DINGELL. This is a unique position, to have an Assistant Secretary for Legislation, as you have in the Department of Health, Education, and Welfare; is that correct?

Dr. DEMPSEY. I do not know that of my own knowledge. There is one Assistant Secretary available for general assignments.

Mr. DINGELL. What are his specific duties and responsibilities?

Dr. DEMPSEY. He has charge of patent problems, he has the international programs of the Department, he has water pollution, and he has civil rights, among others.

Mr. DINGELL. He does not have specific control of the administration of water pollution because that is still vested in the Public Health Service, as a matter of fact. The day-to-day handling of the administration of those programs is in the Public Health Service. He simply has the policy; is that correct?

Dr. DEMPSEY. He has delegated to him those responsibilities which are the Secretary's under the act, and which, for operation are delegated to the Public Health Service.

Mr. DINGELL. You have in addition to that one other Assistant Secretary.

Dr. DEMPSEY. There is one Administrative Assistant Secretary who is a career civil service officer. He is the top administrative officer of the Department.

Mr. DINGELL. What does the Under Secretary of Health, Education, and Welfare do?

Dr. DEMPSEY. He has assignments of various kinds including policy supervision of the Office of Education, and the Welfare Administration, I believe.

Mr. DINGELL. What you are telling me is that he functions as an Assistant Secretary?

Dr. DEMPSEY. No, sir.

Mr. DINGELL. Those two duties that you have described so far are simply the duties of an Assistant Secretary, are they not, and could be performed by an Assistant Secretary; is that correct?

Dr. DEMPSEY. That may be.

Mr. DINGELL. It is not "maybe"; as a matter of fact, it is.

Dr. DEMPSEY. I am sorry, Mr. Dingell, I have to say I am not sufficiently familiar with the delegation of authorities in all of the other departments to be positive in my own mind. I accept your statement.

Mr. DINGELL. Now, let me ask you a little further. What will the Assistant Secretaries who are being set up—and I notice they are three in number—by this legislation do?

Dr. DEMPSEY. I am sorry; I cannot answer the question. We would be glad to provide a statement for the record for you, if you wish, but I would like to refer that to the Secretary.

Mr. DINGELL. I notice from your testimony that you are here to testify on H.R. 2984, which provides for these Assistant Secretaries.

Dr. DEMPSEY. Yesterday the Secretary testified to the provision for additional Assistant Secretaries, since the position that I occupy is also in it. We thought it not appropriate for me to give that

testimony to you, so this was covered in the Secretary's testimony yesterday.

Mr. DINGELL. I read with great interest the Secretary's testimony of yesterday and I have found no statement whatsoever as to what these three Assistant Secretaries are going to do.

Let me turn, if I may, to a further point. Is there any agency within the Department of Health, Education, and Welfare which reports to an Assistant Secretary, and through that Assistant Secretary to the Secretary of Health, Education, and Welfare?

Dr. DEMPSEY. I don't believe so.

Mr. DINGELL. As a matter of fact, there is none; is that correct?

Dr. DEMPSEY. I believe you are correct.

Mr. DINGELL. This also is unique in Government administration, is it not?

Dr. DEMPSEY. I accept your statement.

Mr. DINGELL. Almost every other Department has Assistant Secretaries in charge of this program or that program, or a series of programs, am I correct? And this does not apply within the Department of Health, Education, and Welfare.

Let me ask you this question, which you should know the answer to: Does the Department have any plans, specific in nature, to employ these Assistant Secretaries that they propose to have us set up by legislation?

Dr. DEMPSEY. I am sure there is a plan. I shall be glad to provide a statement for the record for you.

Mr. DINGELL. I searched Mr. Celebrezze's testimony yesterday to see how he proposes to employ the talents and highly paid skills of these Assistant Secretaries that he proposes to have us set up by legislation, and I must confess that I can discern none.

I want to advise you, sir, that I will look with great disfavor upon any statements which are sent up here now to justify the establishment of these positions when witnesses on behalf of the Department appearing in favor of this legislation have not been able to establish at this point in the proceedings any duties or what in my mind is any clear justification for the establishment of these positions.

Thank you very much.

The CHAIRMAN. Mr. Keith?

Mr. KEITH. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Rogers?

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

I would like to get back to H.R. 2987. It is rather confusing to me, exactly what you want to do. As I understand it, any time any group wants to get together and establish a nursing home, this could be done, for instance?

Dr. DEMPSEY. No, sir. The bill proposes that the group should meet standards or requirements prescribed by the Surgeon General. I believe that a nursing home would not be regarded as an eligible activity.

Mr. ROGERS of Florida. According to your definition of a group, if they get doctors agreeable to servicing a certain number of people, they could do it, could they not?

Dr. DEMPSEY. And if that group of doctors had a broad enough coverage of care to satisfy the criteria to be established by the Surgeon General.

Dr. TERRY. Mr. Rogers, may I call this to your attention? Under "Definition" it says the term "group practice facility" means a facility in a State for the treatment of preventive and diagnostic services to ambulatory patients. Then it goes on.

Mr. ROGERS of Florida. Wouldn't nursing homes provide that service as well?

Dr. TERRY. They may, but generally speaking nursing homes are not constructed for this sort of thing. Nursing homes are generally constructed for in-patient care, Mr. Rogers.

Mr. ROGERS of Florida. Is there any program where the Department is involved in the health field in issuing mortgages, checking them out, carrying on a mortgage program?

Dr. DEMPSEY. No, sir.

Mr. ROGERS of Florida. Do you intend to use FHA facilities?

Dr. DEMPSEY. No sir. The bill provides for the Department to administer the program.

Mr. ROGERS of Florida. It says on page 17—

With a view to avoiding unnecessary duplication of existing staffs and facilities of the Federal Government, the Surgeon General is authorized to utilize available services and facilities of any agency of Government.

Dr. DEMPSEY. Yes, sir. I am sorry; I didn't mean to exclude any others. I meant to indicate that the Department is able to carry out the administration of the bill. We would, of course, cooperate with other agencies where this is advisable.

Mr. ROGERS of Florida. Don't you think this would be unnecessary duplication, for you to get into the mortgage business where we have already an agency set up to handle mortgages?

Dr. DEMPSEY. No, sir. This program involves more than the kind of expert knowledge required to handle mortgages, in that it also is involved heavily in medical and health judgments pertaining to the requirements of a medical or dental group, the specialists required to function effectively as a group, and the kinds of equipment and physical facilities required.

We believe, therefore, that a health-oriented agency has a very important role to play in determining the kind of an agency or group which should receive these loans or insured mortgages.

Mr. ROGERS of Florida. What help do you plan to give, or how much money would be expended in actual construction or planning for these facilities? Do you intend to devote any money to this, or is this simply a loan situation?

Dr. DEMPSEY. This is a direct-loan and mortgage-loan situation, sir. We would simply underwrite the mortgages and provide direct loans when necessary.

Mr. ROGERS of Florida. Then you would not need section 907(a), which you have proposed on pages 16 and 17, then?

Dr. DEMPSEY. I believe that, in order to effectively operate this program, we should give, and will be requested to provide, a considerable amount of technical advice to groups who are planning a group-practice facility. The section you mention would make this possible.

Mr. ROGERS of Florida. How much in funds are you going to devote to this? This says "assistance in the planning for and construction of group-practice facilities."

Dr. DEMPSEY. About \$150,000 would be the amount of money required for the first year of operation for the program.

Mr. ROGERS of Florida. If somebody goes ahead and makes this loan, builds this facility after getting technical advice, and they decide they want to move, what would be your action?

Dr. DEMPSEY. The bill provides for the termination of the arrangement under such circumstances.

Mr. ROGERS of Florida. Who assumes the mortgage? Do we go in and pay it, or what happens?

The CHAIRMAN. Is the gentleman in a position that he could suspend and be back in the morning at 10 o'clock?

Mr. ROGERS of Florida. Yes, sir.

The CHAIRMAN. I do so for the purpose of permitting Dr. Russell Teague to file a statement on behalf of the American Public Health Association.

Dr. Teague is the Commissioner of Health of the Kentucky Department of Health. Dr. Teague will be unable to stay over until tomorrow. I think, in order to accommodate Dr. Teague, we should give him an opportunity to file his statement for the record and make any brief comments that he would like to make.

We do want to give you this opportunity to personally present your statement for the record on behalf of the American Public Health Association. We will give you an opportunity to make any further comment. As you know, we have a couple of Kentuckians on this committee. I am not sure which one to recognize first in order to welcome you.

We have the former mayor of one of your great cities, who is a member of this committee, sitting there in front of you. I am sure he knows you and your great work.

We also have one of your well-known and very fine doctors who is here, so Kentucky is well represented.

Mr. FARNSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Farnsley, I will give you an opportunity to say something.

Mr. FARNSLEY. Thank you, Mr. Chairman. He is a great man and we respect him very much in Kentucky.

The CHAIRMAN. Dr. Carter?

Mr. CARTER. I am certainly happy to welcome Dr. Teague up here from Kentucky.

The CHAIRMAN. Dr. Teague, I am very sorry that the inquiries you have heard today of Dr. Dempsey have prevented you from presenting your testimony. We regret that your own schedule will not permit you to stay over. I hope you understand the situation. We will be glad to have any further comments from you, if you would like to make them.

STATEMENT OF DR. RUSSELL E. TEAGUE, COMMISSIONER OF HEALTH, KENTUCKY STATE DEPARTMENT OF HEALTH, ON BEHALF OF AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. TEAGUE. Thank you, Mr. Chairman and members of the committee.

I am proud to represent the American Public Health Association and its 15,000 members throughout the country in support of the four bills under consideration this morning.

I am also delighted to see our distinguished Congressmen from Kentucky on this committee. I assure you I hope to talk with them a little later on.

The four bills under consideration all are good bills. The APHA believes they are progressive and we support all of them, as stated in my statement presented to the committee. I don't want to elaborate on all of them, but just very briefly I will say that the vaccination act that you passed a few years ago has been most successful, and is helping the State and local health departments throughout the country to work with their medical professions in obtaining large numbers of unvaccinated children to get vaccinated.

We would like to see measles added to the list of vaccines that are included in this program. As you know, this requires a nationwide educational campaign to motivate the people to have their children vaccinated. The funds provided in here provide methods by which health departments may do sampling of communities to see how many of the children in a community are unvaccinated, and then put on a special campaign with medical groups to get the job done.

The migrant labor act you passed was an excellent act. The American Public Health Association has just completed a study of projects under this bill. I have before me a copy of the results of this study. The committee will be furnished with this. We recommend a continuation of the migrant labor act, with some improvements. That is one part of one of the bills before you.

The other things I wanted to speak briefly to are the funds in support of staffing the mental retardation centers. You passed a bill last year—the Congress did—to build mental retardation centers, and we now are in the process of providing brick and mortar without any provisions made for staffing these centers. We certainly urge the passage of this legislation.

Certainly the one on group practice, I think, is a good bill. It would tend to provide church groups, unions, and other nonprofit groups, with a means of long-term financing of building and facilities in which physicians might work as a team, all the various specialties being housed in one building to help lower the cost of medical care in the specialties.

We find that where group practice exists, it tends to upgrade the quality of care, and it also tends to provide an academic environment for medicine and tends to cut down on overhead so that physicians can provide additional care at lower cost. The mechanisms are not necessarily within my province. The ideal is that the American Public Health Association supports this kind of practice. That is the point I want to convey.

Mr. Chairman, we are proud to support these four pieces of legislation. We think they are all good bills.

(Dr. Teague's prepared statement follows:)

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION ON H.R. 2984, H.R. 2985, H.R. 2986, AND H.R. 2987, PRESENTED BY RUSSELL E. TEAGUE, M.D., COMMISSIONER OF HEALTH, KENTUCKY STATE DEPARTMENT OF HEALTH

The American Public Health Association appreciates this opportunity to present its views on the four bills under consideration by this committee. We support the objectives of each which, in their several ways, are intended to increase the delivery of health services to our Nation's population and hence to improve the state of health of our people.

H.R. 2984 (except for sec. 4) would amend and expand the Health Research Facilities Construction Act. The need for and the benefits of the act has long been proven beyond question. Continued health research is vital to an increased body of scientific data in order that we may better cope with the many and varied maladies which plague all people and continue to reduce suffering and unnecessary death. It is recognized too that special facilities are required in which health research can be performed. The APHA supports continuance of the present matched financing support program as well as the enactment of the regional or national facilities provision which is proposed as section 712.

In respect to section 4 of H.R. 2984, the APHA is inclined to agree with the apparent rationale. The office of Special Assistant to the Secretary for Health and Medical Affairs is something of an administrative anomaly. It would seem to us, however, that in consideration of the importance of our Nation's health efforts, the magnitude of health responsibilities of not only the Public Health Service but of the Social Security Administration and the Vocational Rehabilitation Administration and, under this administration proposal, the number of Assistant Secretaries to be available, that one of the proposed Assistant Secretaries should be a physician. This recommendation should not be construed as a denigration of the efforts of nonphysicians who have served as Special Assistants for Health and Medical Affairs. Certainly the services of Mr. Jones were of the highest quality, and the credentials of the incumbent, Dr. Dempsey, are impeccable. We do believe, however, that as in the instances of other specialized competencies, the unique training and experience of a physician would be not only appropriate but desirable and of benefit.

H.R. 2985 would authorize Federal funds to support a portion of the cost for professional and technical personnel required for the initial staffing of the community mental health centers approved by Public Law 88-156. The committee will recall that it was the intent of that legislation to locate and make available to persons suffering from mental disorders psychiatric and other appropriate health services closer to their homes and on an outpatient basis. It was to help break the now outdated pattern where, in the main, mental hospitals and the bulk of needed therapeutic services are housed in large hospitals, usually far removed from resources of health personnel, facilities, common services, and medical schools. The APHA fully supports this long overdue pattern change and wishes to point out that all needed support must be given so that these centers will not become empty monuments of brick and cement due to an absence of staff nor should they be allowed to provide inferior care.

H.R. 2986 proposes extension of four existing programs whereby Federal support is provided to State and local public health programs throughout the Nation.

We support section 2 both as it would extend and expand the Vaccination Assistance Act and remove the appropriations limitation presently applicable. This program is an outstanding example of combined local, State, and National effort to rid our Nation's people of preventable disease and disability with their resulting suffering and loss, both physical and economic. The progress during the few short years of this program's existence has, we believe, been commendable; and on that basis, together with the need for continued vigilance against poliomyelitis, diphtheria, whooping cough, and tetanus, the continuation of the authority is merited. We believe, too, that because of the problems posed by measles and, more particularly, the deleterious effects which may result from the disease such as encephalitis, brain damage, and others, and because a specific preventive agent is available, that the act should include support for measles vaccination programs.

Section 3 of H.R. 2986 provides extension and expansion of support of health services for domestic migratory agricultural workers and their families. The APHA is pleased to have been a strong supporter of this program when it was first enacted 3 years ago. We contended, and the Congress agreed, that these citizens, whose labor is vital to important segments of our farm economy but whose necessary intercounty and interstate migrations deprive them of legal residence status, posed a truly national problem. We were in complete agreement with the premise that the Federal Government did have a distinct responsibility to aid in providing health services to these workers and their families.

The APHA has recently concluded a critical appraisal of this program. The full report of this study is available to this committee, and a copy of the summary of findings and recommendations is furnished for the record. Briefly, it was found that the program has been competently administered and that the modest amounts which were appropriated have contributed materially to vitally needed health services and have resulted in an elevated and improved status of health among these migrants. Because of the limited funds it was impossible, however, to

provide assistance that was inclusive geographically or a range of services as broad as is needed. It was specifically recommended, for example, that some funds should be available for necessary hospital care. The APHA urges extension of this authority with an increase in the authorization ceiling for appropriations consistent with demonstrated need.

Section 4 of H.R. 2986 would extend for 1 year the authority of sections 314(c) and 316(a) of the Public Health Service Act. We support this limited extension because within a year we expect to have comprehensive and authentic information on improved methods of providing community health services which should provide valuable documentation to this committee and to public health agencies throughout the Nation. Together with the National Health Council we are presently sponsoring the National Commission on Community Health Services, whose Chairman is the extremely well qualified Mr. Marion Folsom. The Commission, with task forces comprised of exceptionally talented and experienced health leaders, is presently in the final year of a 4-year study of community health services including their organization, adequacy, deficiencies, areas of need—all important features of this matter. The results of this endeavor will be available in early 1966 and, it is hoped, will be of interest and of assistance to this committee. Because this body of information will soon be available, we support the 1-year extension of section 314(c) and section 316(a) as proposed in H.R. 2986.

H.R. 2987 would authorize the Surgeon General, U.S. Public Health Service, to finance, within the limits of amounts specified in the bill, mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry. At present, consumer sponsored, nonprofit, prepaid group practice clinics not affiliated with a hospital are excluded from Federal financial support. The APHA has found that these nonprofit groups have generally stressed preventive services and rehabilitation, have prevented unnecessary hospitalization, and have provided economies in medical services yet provided health services of high quality. As the committee knows, it is difficult to obtain long-term, low-interest-rate loans for the construction of needed facilities from other than governmental sources. The APHA therefore does support long-term Federal loans to those nonprofit, prepaid group practice plans which meet professional standards established by the U.S. Public Health Service in cooperation with State and local health agencies.

The APHA is most appreciative of this opportunity to present, on behalf of its 15,000 members, our views on these legislative proposals.

The CHAIRMAN. Thank you very much, Doctor. As I say, I am terribly sorry that our time has not permitted us to hear you this morning at length. We do thank you for your statement. We are glad to have the views and recommendations of the great organization of which you are a part.

Dr. TEAGUE. Thank you, sir.

(Dr. Teague later submitted the following additional information:)

RECOMMENDATIONS RESULTING FROM THE EVALUATORY STUDY ON OPERATIONS OF THE MIGRANT HEALTH PROGRAM UNDER THE MIGRANT HEALTH ACT

1. It is recommended that the Migrant Health Act (Public Law 87-692) be extended 5 years beyond its current expiration date with a review to be conducted at the end of 3 years and with consideration given to suggested modifications designed to enhance its effectiveness.
2. It is recommended that congressional appropriation of an amount not less than \$10 million be authorized annually to finance continued operations of the Migrant Health Act, and that such appropriation include sufficient funds to provide necessary medical and hospitalization coverage for domestic seasonal farmworkers and their families.
3. It is recommended that State and local governments should eliminate their residency requirements as a basis for receipt of hospitalization services public assistance. To encourage such assistance to needy migrant families, such as programs for aid to dependent children, larger Federal public assistance grants should be given to counties with substantial numbers of migrant families when such residency requirements are eliminated.
4. It is recommended that consideration be given to financing special seasonal farmworkers health studies to be conducted by responsible National, State, and local organizations.

5. It is recommended that the term "domestic agricultural migratory worker" be changed to "domestic seasonal farmworker" and that this latter term be used in all subsequent legislation respecting eligibility for coverage under the Migrant Health Act.

6. It is recommended that efforts be continued to pass legislation aimed at improving the situation of migrant seasonal farmworkers in regard to a minimum law, unemployment insurance, workmen's compensation, child labor, and the right to collective bargaining.

7. It is recommended that consideration be given to ways and means of establishing community health service clinics, particularly in rural areas throughout the United States, utilizing already established medical channels in all communities where such services are available, which is in keeping with the policy statement of the APHA adopted at their 91st annual meeting, November 10, 1963.

8. It is recommended that principal emphasis be given to financing projects which give evidence of developing truly comprehensive health service including medical care.

9. It is recommended that application procedure and reporting forms be greatly simplified for use in the migrant health grants program.

10. It is recommended that close cooperation be maintained between the Public Health Service Migrant Health Branch and the Office of Economic Opportunity, to obtain maximum benefits to rural areas through coordination of health services and facilities provisions of these two congressional acts.

11. It is recommended that (a) intensive effort be directed toward developing a uniform basic core of health services in all areas where projects are located; (b) attention be given to developing and implementing an effective patient record and referral system; and (c) methods of improving interarea communication and coordinated use of health resources be explored, in order than continuity of health care may be provided.

12. It is recommended that family planning be included as an integral part of health service clinics which also should make available medical advice and services acceptable to the individuals concerned.

13. It is recommended that (a) the current PHS regional structure be modified to encourage freedom of movement of the consultative staff in accordance with the interstate movement of migrants, and (b) the present consultative staff in Washington be appropriately supplemented with staff to give increased attention to program development and evaluation along the major migrant streams.

14. It is recommended that the effective employment of subprofessional health personnel be encouraged and, when possible, recruited from the indigenous group. This should be promoted wherever appropriate under proper supervision. The training, placement, and use of community health aids in migrant health projects should be examined and evaluated to this end.

15. It is recommended that training centers in intercultural understanding be established in important areas of migrant concentration and that participation in such programs be encouraged for both professional and subprofessional members of the migrant health staff.

SUMMARY OF CONCLUSIONS

General

1. The Migrant Health Act (Public Law 87-692) is the first effort by Congress specifically to meet the health needs of domestic migrant agricultural workers.

2. The program under the Migrant Health Act has operated completely within congressional intent.

3. The act has permitted local groups to initiate projects to improve health services to migrants.

4. The continuation of the act will permit increasing the interstate cooperation already in evidence, and the development of greater continuity of health care for migrant agricultural workers.

5. Applications for project funds have been greater than the amounts appropriated, indicating increasing interest among health officials and others about migrant health problems and related areas of unmet need.

6. The Migrant Health Act has demonstrated that the small initial appropriation allotted to attack a large national problem is totally inadequate. Extensive field activities, by both local and State personnel, have demonstrated with dramatic clarity that health needs and ability to meet such needs are, as a rule, virtually identical with migrant and nonmigrant alike.

7. Due to delay in appropriation, the program began a year late and has not been able to demonstrate fully its potential benefit to migrant workers.

8. Program operations have broadened the public health services in many areas to include early medical care as part of the preventive services afforded migrants.

9. Through demonstrations in several projects, it has become apparent that the training of personnel in migrant health work deserves additional attention in the subtleties of cross-cultural understanding and communication.

10. While it was hoped that the financial responsibility for ongoing projects would gradually be assumed by local support, experience in most areas discloses that withdrawal of Federal funds would seriously undermine the program.

Benefits of program

1. The program is providing services that would not be available without the Migrant Health Act.

2. It has stimulated greatly local interest in migrants throughout the country.

3. It has resulted in marked improvement in communication among health workers, growers, and migrants.

4. It has brought into focus the need for continuity of health services in dealing with a highly mobile population.

5. It has resulted in improvement of housing, general sanitation, working and living conditions in a large number of localities.

6. It has encouraged the establishment of family health clinics or other means of providing medical care for migrants, which in turn has led to better utilization of traditional public health services.

7. It has provided medical and health services not previously available in many rural areas, and in many instances has extended these services to local impoverished rural residents supported by local funds.

8. In some areas where projects did not extend coverage to other than migrant workers, local residents have requested that equivalent services be established for other local poor.

Limitations of program to migrants

1. Slightly more than 50 percent of projects established the family health service clinics which were the primary goal of Public Law 87-692.

2. Health service clinics now operate only once or twice per week, and are unable to offer comprehensive medical service.

3. Inability to pay for hospitalization and private medical care often restricts or negates potential benefits from clinic service, by preventing patient followup on necessary additional medical care in both emergency and rehabilitative situations.

4. Staff-patient communication, especially in projects having Latin Americans in both clinical and related health activities, is conspicuously ineffectual except when interpreters or bilingual health personnel are included as members of a project team.

5. Due to population fluctuation, clinic facilities are not always easily accessible, necessitating the use of available but inadequate resources within a circumscribed area.

6. The absence of any transportation in many areas prevents effective clinic use, and nullifies benefits of referrals to more distant medical centers.

7. Clinics are not always held at times and places most convenient to the worker and his family.

8. All but a few clinics reveal definite understaffing of physicians, nurses, and auxiliary personnel.

9. Projects which include "studies" have been restricted by intent of the act. And yet, without this feature, certain accurate essential information cannot be gathered against which programs might be evaluated.

MIGRANT HEALTH STUDY, AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,
WESTERN REGIONAL OFFICE, SAN FRANCISCO, CALIF.

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The CHAIRMAN. Dr. Dempsey, could you return in the morning?

Dr. DEMPSEY. Yes, sir.

The CHAIRMAN. The committee will recess until 10 o'clock in the morning, at which time, Dr. Dempsey, you will return.

(Whereupon, at 12:10 p.m., the committee recessed, to reconvene at 10 a.m., Thursday, March 4, 1965.)

RESEARCH FACILITIES, MENTAL HEALTH STAFFING, CONTINUATION OF HEALTH PROGRAMS, AND GROUP PRACTICE

THURSDAY, MARCH 4, 1965

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met at 10 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will please come to order.

The first thing this morning I would like to do is to extend a cordial welcome to the newest member of this committee.

Our distinguished colleague from Georgia, Mr. Callaway, was assigned to this committee yesterday by the House to fill the vacancy that was left recently when our colleague from South Carolina resigned from the Congress. I would like to note Mr. Callaway's appearance this morning, and to comment for the benefit of all of the members, that here is a new member who has just been assigned, and the very first day he showed up at the hearings. Let that be a lesson to everyone.

I would like to say, in all seriousness, we are glad to have you and look forward to working with you and you working with us as we share the tremendous responsibilities together.

Mr. CALLAWAY. Thank you, Mr. Chairman. It is an honor to be here.

The CHAIRMAN. Mr. Springer?

Mr. SPRINGER. I have gone into Mr. Callaway's background. I feel he is amply qualified to serve on this committee with such a delightful group and told him, if he was not the same kind, we would take him off the committee.

We are happy to have Mr. Callaway not only on our side, but on this committee. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Murphy?

Mr. MURPHY. Mr. Chairman, Mr. Callaway and I spent 3 years together at a little military school on the Hudson, and even if he is sitting on that side of the aisle, I would like him to know it is a pleasure to be on the same committee with him.

The CHAIRMAN. I am glad to know of this association. It might be helpful as we continue.

Mr. PICKLE. Mr. Chairman——

The CHAIRMAN. Mr. Pickle?

Mr. PICKLE. I am glad to know that Mr. Callaway and Mr. Murphy have gone to school together, I assume at West Point. Perhaps that is one reason why, 2 weeks ago, he and I went on a submarine cruise in the Atlantic, and he is trying to get rid of some of that background. He is a wonderful fellow.

The CHAIRMAN. Before we get too far away from the business of the day, as interesting as this is, let me say that as we continue this morning the hearings on four important bills, H.R. 2984, H.R. 2985, H.R. 2986, and H.R. 2987, submitted by the administration, through the Department of Health, Education, and Welfare.

It is a privilege, in behalf of the committee, to extend a cordial welcome to the distinguished Governors who are here today in the interest of this legislation.

We are very glad to extend a welcome, first, to the Honorable Otto Kerner, Governor of the great State of Illinois, or should I say the great Governor of the great State of Illinois; and also to the Honorable John Volpe, the great Governor of the great State of Massachusetts.

We note also that the Governor of the State of Connecticut, who is one of the team of three Governors to appear today, is appearing before the Senate, and he will be coming over when he has concluded over there.

We will proceed, however, in order that we can get to these distinguished public servants who have such vast responsibilities and, we know, heavy schedules.

At this time, Governor Kerner, we would be glad to extend to you the courtesy of the witness chair. We would be glad to have you present whatever you wish to this committee on the subject, or the two or three of you, as the case may be, when Governor Dempsey gets here. If you have a program of your own about your presentation, we will turn over to you whatever time you need to proceed and be glad to receive it.

Governor KERNER. Thank you very much, Mr. Chairman.

Governor Volpe has other commitments. He seems to have a little railroad problem in Massachusetts. We have agreed that Governor Volpe will speak first, if it meets with your approval.

The CHAIRMAN. Governor Volpe, we will be glad to have you. This committee knows something about the problems that you are involved with, other than the matter before the committee at the present time. We have had problems with that railroad before this committee on several occasions.

It seems that we have a hard time ever getting a final resolution on their problem, and if you can work it out, my hat is off to you.

STATEMENT OF HON. JOHN A. VOLPE, GOVERNOR OF THE STATE OF MASSACHUSETTS

Governor VOLPE. Thank you very much, Mr. Chairman. We have been working at it.

It is a privilege to be here this morning and to testify before this distinguished committee in behalf of H.R. 2985. I do so enthusiastically. This measure, now in its first public hearing before the Congress, is designed to bring to the community mental health movement the strength and the capacity to really do its job.

I think all of us here realize, as we in Massachusetts are so fully aware, that the community mental health concept and structure are the most significant new development we have yet seen—to bring the practice of preventive and restorative psychiatry to all of our people.

I can say this today in the light of the experience that we in Massachusetts have had for the last full decade. The first community mental health center in the country was established near the downtown section of Boston at a time when psychiatry itself was only slowly moving toward new concepts and practices.

Let me recall that in 1958 our present Commissioner of Mental Health, Dr. Harry C. Solomon, became president of the American Psychiatric Association. I am sure we all know that for too long the State mental health hospital system has been the hallmark of psychiatry's ability to reach and help the vast numbers of our people who are mentally ill in some degree.

This bill, by authorizing Federal aid to help meet the cost of staffing mental health centers, picks up where the legislation of the previous Congress left off. The 88th Congress, through the efforts of some of the Members present here today, provided funds to aid in the construction of facilities, but facilities without adequate staff are, of course, merely bricks and mortar.

Now, I am well aware of the fact that there are some who have argued during the past 2 years that while Federal funds may be used for facilities, they should not be used to help centers finance their personnel. To my mind, this is a position that does not have regard for either the needs nor the facts of public health in today's modern society.

The strongest statement of those taking this position appears to be that the community should assume the basic responsibility for the mental health care of its citizens. Now, many of us agree that the basic responsibility is the community's, but contend that the community needs help during this transition period. Upgrading the level of care in our mental hospitals is a great and challenging burden, and we find that we are already straining our resources before the new community center program is really launched.

The Massachusetts Legislature approved mental health legislation long before the Federal Government acted in this field. Massachusetts has gone steadily ahead in attempting to meet a whole range of mental health problems, from mental illness to alcoholism, to the care of disturbed children, and care of the elderly. But we still need to bridge a wide gulf, as do all the States, in crossing from the old mental hospital—custodial treatment—to the new approach in mental health, and we need the temporary aid provided by H.R. 2985 to get our planned program going.

In Massachusetts alone, hundreds and hundreds of citizens have participated actively in planning stronger and better mental health services, and there is broad representation of many organizations in the effort. Our State medical society is among the cooperating groups and is now cosponsoring a survey of physicians and of the mental health problems which confront them in their practice.

Mental health planning has gone ahead and will continue at a rapid pace. Following an extensive survey of needs and resources, we have divided our State into 38 areas to be served by mental health centers. At the moment, we have committed ourselves to centers in

seven key locations. In addition, five of our State hospitals are to be overhauled to join the new community mental health movement.

We do not want our prospects of success to be frustrated by the difficulties of many communities in the inauguration of the new program.

Three weeks ago, the director of our mental health planning project wrote to the regional office of the Federal Department of Health, Education, and Welfare. In his letter he made the following point, and I quote:

One of the great problems is that of adequate funds for staffing. My guess is that it will be the most serious problem by the fiscal year 1967. Help will definitely be needed.

Now, this appeal by our planning director will be echoed by other States, I am sure. Failure of this Congress to act in this respect will be a frustrating disservice—a disservice to the people who cannot afford private psychiatric care. This includes most of the Americans in need of such care.

Other witnesses will appear before you. Some may review the great new concept of unified and comprehensive mental health care in the community. Others, who are experts in local and State financing, may discuss the complex financing structure that will be needed to make these centers a reality. Funds will be needed from both public and private sources. Sources range all the way from voluntary insurance plans through community funds, State funds, and fees that patients are able to pay, but we cannot overlook the dire need for substantial support from the Federal Government to launch our program.

In your deliberations over this bill, I feel that emphasis must be placed on two main facts: One is the tremendous cost of maintaining the present State mental hospital system. The other is that, until such time as savings can be effected in that respect by the establishment of mental health centers in our communities, we need special aid.

In Massachusetts, we are investing about \$51.5 million annually to maintain our mental hospitals. We need time to learn just how to budget the new center system. We know, for example, that inpatient care in a center costs about \$27 a day, while State hospital care costs about \$7 a day, but we also know that care in the centers averages about 2 weeks to 1 month, while State hospital care averages 6 months.

The gradually declining Federal support for a limited period of years for staffing centers is not only needed, but it is a commonsense move directed toward helping us get on our feet.

Another point I would make is that there is no historical precedent for the assumption that Federal aid in the field of mental health lowers community responsibility and raises Federal control. To the contrary, it is precisely because we recognize State and community responsibility in the care of the mentally ill that we now urge upon the Congress passage of H.R. 2985 to help us fulfill our intent and responsibility.

The bugaboo of Federal control is as obsolete as the old mental hospitals themselves. Mental illness is everybody's business. Back in 1947, the Federal Government established a system of formula grants to the States to aid in supporting mental health services. Last year, the Federal Government invested \$6,750,000 for this purpose. That same year, the investments of the States exceeded \$100 million.

The Federal support stimulated and helped the State and private action, and it would be a tragic step backward now to assume initial staffing aid will somehow cause Federal control or the usurping of community and Federal responsibility.

In closing, I should like to make the point that this situation goes beyond Massachusetts, beyond New England or any other section, and straight to the heart of our whole society. The point is that all of the resources of a modern society must be mobilized to meet such vital needs as this, and neither this bill nor any other needed health legislation may be rightly viewed as partisan in any sense of the word. I know that this Congress will not so view H.R. 2985, the passage of which I most urgently recommend.

Thank you.

Mr. FRIEDEL (presiding). Thank you, Governor, for your very fine and precise statement.

I understand Governor Volpe has to appear before the Senate at 10:45. I will ask the members to be brief in their questioning so we do not delay his appearance before the Senate.

Mr. KORNEGAY?

Mr. KORNEGAY. Governor, let me join the committee in welcoming you here today and express my appreciation to you for your very fine statement. I did not get a copy of your original statement and I missed a figure which you gave on how much the State of Massachusetts is spending on mental health and mental care.

Governor VOLPE. \$51.5 million annually.

Mr. KORNEGAY. Do you have any sort of program as a State for area or community mental health centers?

Governor VOLPE. Yes. We have one, the oldest, the Massachusetts Mental Health Center in Boston. We have one on which ground will be broken within about 6 weeks, and we have six others that are under various stages of design. We hope to have all eight of these in operation within the next 2 years.

Mr. KORNEGAY. Was this plan conceived and commenced prior to the enactment of the Mental Health Facilities Act by the Congress in the 88th Congress?

Governor VOLPE. Yes; some of these were conceived before and some after.

Mr. KORNEGAY. Massachusetts has come to the conclusion that some changes were needed in the care and treatment of the mentally ill, to get away from the old custodial care approach to the new approach of treatment in the local communities.

Governor VOLPE. Very definitely, sir.

Mr. KORNEGAY. Thank you very much, Governor.

Governor VOLPE. You are quite welcome.

Mr. FRIEDEL. Mr. Springer.

Mr. SPRINGER. Governor Volpe, I think you have done a great deal of good by coming here to make this fine statement. I have just this one question:

From your statement, I take it that ultimately you will have 12 centers in Massachusetts.

Governor VOLPE. We now have 31 mental health clinics. In addition to those we will have seven mental health community centers, as well as five State hospitals where we will be operating community mental health centers.

Mr. SPRINGER. You will have 30 clinics?

Governor VOLPE. Thirty-one.

Mr. SPRINGER. And seven key locations?

Governor VOLPE. Yes.

Mr. SPRINGER. And then you are going to use your five State hospitals?

Governor VOLPE. Yes.

Mr. SPRINGER. That will be a total of 43.

Governor VOLPE. That is correct.

Mr. SPRINGER. How many people are there in Massachusetts?

Governor VOLPE. 5¼ million.

Mr. SPRINGER. Do you think on that basis that 43 will do the job?

Governor VOLPE. We are not certain that it will do the job. We believe that it is an excellent start. It is quite possible we may have to have more than this number, sir.

Mr. SPRINGER. How many counties are there in Massachusetts?

Governor VOLPE. Fourteen.

Mr. SPRINGER. Fourteen counties?

Governor VOLPE. Yes, sir.

Mr. SPRINGER. That is all, Mr. Chairman.

Mr. FRIEDEL. Mr. Dingell?

Mr. DINGELL. No questions.

Mr. FRIEDEL. Mr. Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

Yesterday our colleague, Hastings Keith, outlined to us the fine work that has been done in Massachusetts, and we appreciate it very much.

In regard to H.R. 2985 on which you testified, there is no definite provision in the bill as to where this money is to go. The grants are to be made to the applicant, apparently. It is true that the State must approve the application before it comes through.

I would like to ask you, as a Governor, do you want this money to go direct to the applicant or do you want some supervision in the State as to how this money is to be used?

Governor VOLPE. It would be my opinion, sir, that there ought to be a coordinating body in the State to handle it.

Mr. YOUNGER. And that the money should go to the State and not to the applicant for use?

Governor VOLPE. That would be my opinion, sir.

Mr. YOUNGER. Then you would prefer to have the bill amended in that manner?

Governor VOLPE. That is correct, sir.

Mr. YOUNGER. Thank you, Mr. Chairman.

Mr. FRIEDEL. Mr. Rogers, have you any questions?

Mr. ROGERS of Florida. No questions.

Mr. FRIEDEL. Mr. Devine?

Mr. DEVINE. No questions, Mr. Chairman.

Mr. FRIEDEL. Mr. Pickle?

Mr. PICKLE. I want to commend you for your statement, Governor. There is a good bit of interest in my State for this legislation and I support it in principle.

I would like to ask you, on the centers which you are operating now, under the Community Mental Health Centers Act of 1963, which set up the program, is any of that Federal money going to pay for staffing of your centers now?

Governor VOLPE. No, it will not. About \$800,000 will be coming to Massachusetts for construction purposes only.

Mr. PICKLE. Are you saying that you do not think your State would be able to meet the cost of any of the staffing expenses in connection with these centers?

Governor VOLPE. We are not saying that we wouldn't be able to meet any of the staffing expenses. I have requested our legislature to come up with \$215 million in new revenue. We are saying that the cost of the State government is increasing by leaps and bounds, and we feel the need for doing something constructive in this area.

We are willing to assume our share of the cost. We believe, however, during this transition period, probably about a 5-year period, that the Federal Government legitimately could, and in our belief ought, to help in the staffing of these centers.

Mr. PICKLE. Do you think that there should be any ceiling put on the amount of money we could appropriate for this particular bill?

Governor VOLPE. If I were sitting in your chair, sir, I would certainly want a ceiling.

Mr. PICKLE. Thank you very much.

Mr. FRIEDEL. Dr. Carter?

Mr. CARTER. I would like to compliment the distinguished Governor for his excellent presentation.

Governor VOLPE. Thank you, sir.

Mr. FRIEDEL. Mr. Rooney?

Mr. ROONEY. I, too, would like to join my colleagues in complimenting the distinguished Governor from the Commonwealth of Massachusetts on the excellent statement and his support of this very important bill.

I have one question, however. That is on page 4 of your statement. For example, in-patient care in a center costs \$27 a day as compared to \$7 a day in your State hospitals. How can you explain that very large gap between the in-patient care and the hospitals?

Governor VOLPE. In our State hospitals, and I don't think they are warehouses, but they have been called warehouses of human beings.

Mr. ROONEY. You mean hospitals of custodial care?

Governor VOLPE. That is correct. I think ours long ago ceased being warehouses, but, on the other hand, with the amount of treatment and care that can be given in a large institution, with 2,000 people—by the way, since we started this program, one of our custodial hospitals has gone from 2,800 patients down to 1,700, as a result of the new and enlightened treatment that we are giving there as well as the diversification, of course, of these community mental health centers.

But the great difference is that whereas the State hospital is primarily just for custodial treatment, with very few personnel in relation to the number of patients, in the clinic or in the mental health center, of course, you have much higher cost by way of personnel, and the treatment, of course, is much more intensive.

That is the reason for the much higher cost, plus the fact that usually these centers are in the center of a city where in the first instance your cost is much higher than it would be at a State hospital, which is out in a rural area.

Mr. ROONEY. Thank you. I have no further questions.

Mr. FRIEDEL. Mr. Callaway?

Mr. CALLAWAY. I have no questions, Mr. Chairman.

Mr. FRIEDEL. Are there any other questions?

If not, Governor, I want to thank you for your very fine statement. I am glad to hear you say you appreciate the brick and mortar and now you want staffing. I hope we do it for you.

Governor VOLPE. Thank you very much for your courtesy, gentlemen.

Mr. FRIEDEL. Now we have the pleasure of hearing Gov. Otto Kerner, of Illinois.

Mr. SPRINGER. May I say, Mr. Chairman, that the distinguished Governor of Illinois has long been interested in mental health and has taken the lead not only in the State of Illinois, but nationwide, trying to alert people to the need for mental health and also for support for the program.

The Governor has with him also Dr. Harold Visotsky, who is director of the Mental Health Department of the State of Illinois, and one of the outstanding experts in the world on this subject.

Mr. FRIEDEL. We are pleased to have you with us, Governor. You may proceed.

STATEMENT OF HON. OTTO KERNER, GOVERNOR, STATE OF ILLINOIS; ACCOMPANIED BY HAROLD M. VISOTSKY, M.D., DIRECTOR, ILLINOIS DEPARTMENT OF MENTAL HEALTH

Governor KERNER. Thank you, Mr. Chairman. I am delighted to be here on this occasion to take advantage to present to the members present our views in Illinois concerning mental health and particularly with reference to House bill 2985.

Before I begin my own presentation, a neighboring Governor of ours has asked me to present his views, a short statement. That is a statement of the distinguished Governor of Wisconsin, Gov. Warren P. Knowles, in which he states:

It is my understanding that House Resolution 2985 of the 89th Congress is legislation designed to provide for assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers.

In Wisconsin, with our strong tradition of local mental health services, we are greatly interested in such centers for our communities. However, we do foresee difficulties in making such centers operational unless partial support of initial cost of personnel is made available.

Before I begin my statement, I have been interested in mental health problems, of course, from my war years. I see two members from that school up the Hudson. I was pleased and honored to serve for 2 years with a very fine young soldier by the name of General Westmoreland, whom I have regarded very highly.

But it was in those war years that I first ran into these problems on a personal basis. Upon my return, after the war years, I was county judge of Cook County, which judgeship no longer exists.

That judgeship exclusively had the problems of mental health of more than one-half of the residents of the State of Illinois, some 10,000 petitions a year being filed in that court. So sitting in that court, I could not help but take a very personal interest in all problems of mental disturbance, be they at the children's age or infant age with mental deficiency, all the way through the senile dimension troubles.

Before I begin my statement, I would, with the chairman's permission, like to put into the record our mental health bulletin in Illinois

for January–February 1965 particularly the article on page 1, “Community Mental Health: A Three-Way Split,” which I think is the philosophy to which I espouse.

Mr. FRIEDEL. If there is no objection, that will be included in the record.

(The article referred to follows:)

[From *Mental Health in Illinois*, January–February 1965]

COMMUNITY MENTAL HEALTH: A THREE-WAY SPLIT

In coming years, numerous Illinois Department of Mental Health workers will spend about one-third of their time enlisting the aid of, and cooperating with, a myriad of public and private agencies in the tasks of keeping more people mentally healthy and helping those who become ill.

This was a key point made by Dr. Harold Visotsky, director of mental health, in a recent interview.

The hours spent with the teachers, ministers, doctors, nurses, employers, politicians, welfare workers, policemen, and others who work in these agencies will be precious ones because the mental health people must, at the same time, adopt better ways of doing their traditional jobs—treating the patients who come to them and returning them to homes, jobs, and schools.

But the time will be well spent because it can pay dividends, long-term ones especially.

The department of mental health can't and shouldn't meet all the mental health needs of the State. It can't and shouldn't correct every condition in society that may drive people into State institutions.

The problems needing solutions are partly local responsibilities—and overlap the fields of health, education, welfare, religion, safety, employment, city planning, economics, penology, and sociology. Workers in these fields do things that affect people—and their mental health—for better or worse.

Cooperating with these specialists to help large numbers of people in trouble brings the mental health worker out of the clinic, out of the hospital, out of the office with couch, and into the arena called community mental health.

The concept of community mental health is not new, but the application of it has been rare and spotty. Illinois, now drawing up a statewide plan, intends to do something about it. The State plan, to be completed by September 1, will serve as a guide for interagency planning in hometowns.

Meanwhile, Dr. Visotsky has expressed many of his views on the topic in speeches, meetings, and news stories. What follows are excerpts from an interview with him on interagency cooperation and some other facets of the subject:

“IT'S BIGGER THAN THE DEPARTMENT

“When you begin to plan comprehensively for community mental health, you look beyond the clinic or other facility specifically responsible. You look at the school, the church, the health department, the YMCA, the family counseling service—all the agencies interested in people. And you try to see how they might fit into an integrated program. You see them not only as resources for treating mental illness, but also for preventing it. From this vantage, you see that a program should encompass many workers who do not see themselves as mental health resources.

“There aren't enough mental health people to do all the jobs. There are fewer than 600 psychiatrists in Illinois and most of them are in private practice in the Chicago area. County after county doesn't have a psychiatrist within 100 miles. There are similar shortages of psychologists, psychiatric social workers, and psychiatric nurses * * * If the community looks to us as the only mental health resource, we remain a limited, overworked agency. But if we join with the resources in the community our ability to provide a greater spectrum of services is at hand.

“Mental health people in spite of their training are not fully aware of the problems of communities, and they must learn from other experts. The policeman and judge have something to tell us about juvenile delinquents, the sociologist has some information about how families are changing, the family doctor knows his patients better than we do, and so forth.

“Much can be done in a well-organized community program to reduce disability in individuals. Much of the mental illness we see in our State hospitals is a

result of a poorly organized community. There is a group of individuals who—because of their being poor, deprived, and disadvantaged—cannot get access to a good education, jobs and other sources of personal attainment. Neither can they get psychiatric help. Their communities are not concerned with dealing with individuals in distress. So they grow sicker until they receive what I think is a drastic form of treatment—state hospitalization.

“Ministers, family doctors, and public health nurses are among the resources individuals have when they become upset. They and many others are doing work bordering on mental health whether they realize it or not. Our job is to consult with them—to help them give their advice and show their concern in a more organized, meaningful, educated fashion—to help them find early treatment for their people.

“AGENTS OF ACCESS

“If they are well oriented, they will know their limitations and send people in trouble beyond their competence up to the next echelon. * * * They will be able to spot for us many of the people who shouldn't have to become seriously ill in order to get someone to intervene for them.

“Many community professional persons are seen by the people as more acceptable resources than psychiatrists. A person in stress will go to a minister or public health nurse or social worker when he wouldn't think of going to a psychiatrist. These professionals can be agents of access to the psychiatrist, intervening and getting the patient early to treatment.

“For example, in one community we plan to pay half the salary of a social worker if the school system will pay the other half. She will work half time in the schools and half time in one of our clinics. The problems she sees at school in the mornings she can refer directly to herself in the clinic in the afternoons. She will be able to say to the mother of a child who is acting up: ‘I think your child has emotional problems. Why don't you see me and the doctor on Tuesday?’

“She is able to say this in a setting that is not psychiatric, and the mother, having discussed the child with her, has some confidence in her. This way, there is a better chance the mother will bring the child to the clinic. She isn't so likely to stay away out of fear some psychiatrist will label her a nutty mother. * * * If a family is hostile and threatened at the idea of treatment, they are not likely to bring a child in and the child is not likely to benefit if they do. * * * This is the kind of thing we can do in partnership with the community.

“ON GETTING TOGETHER

“We will have community organizers—people who are adept at dealing with social agencies. It is their job to get the people in the various agencies together and talking with our planning people. If out of this plan comes a need for orientation sessions or workshops, we will provide them. But the important thing is to bring these people together, tell them what our role is, and help them examine themselves to see what their role is. The biggest problem with agencies today is that their roles are fuzzy. The area between emotional disturbance and social disorganization in an individual is a gray one. Where does the youth worker stop and the psychiatrist begin? * * * There are many gray areas as our society becomes more complex, so meeting with these various groups in the community is in part to define roles.

“ALREADY SOLD ON TRAINING

“It is no longer a major task to sell the idea of getting some mental health know-how into the preemployment and inservice training of the various community professionals. However, there is the problem of manpower for teaching. We already run two chaplaincy training programs in State hospitals and theological seminaries frequently want courses taught. We also teach police officers in some localities about handling patients.

“It is important that all professionals who deal with people get some training in human behavior. If they spend a lot of time with personal problems they should get more advanced training. Our staff members cannot do all the teaching because if they did they wouldn't have time to fulfill another prime responsibility, which is to get in and provide early access for treatment for patients. What they can do is help plan training programs, and help locate psychiatrists and psychologists not assigned to our department who may be able to teach.

"I tell mental health professionals who come to work for me that their jobs probably will be split three ways—one-third on direct services to patients, one-third on training within our department and outside it, and one-third on community organization, planning, and consultation.

"NAIVETE, NOT UNWILLINGNESS

"If a community is totally unaware of mental health planning and programing, we will go to them. But nowadays, the emphasis on mental health is so great we don't have to seek out many communities. They know they need mental health programs, but are bewildered and haven't planned coherently. Oftentimes, what we must do is show them where we can match them—in funds, staff, or both—to meet their needs.

"We find not unwillingness, but naivete. Many communities think that the department of mental health will fill all their needs—that a mental health clinic would solve all their problems. Actually, they may need a number of precursors to what is generally considered a mental health program. The precursors might be a family service agency, a social worker in their schools, a marriage counseling service, a youth division in their police department, a self-help program in which people begin to get jobs and groceries, or a psychiatric nurse in their public health department.

"One community agency has set up what they call a financial review clinic because they found that many of the people who came in talking about 'emotional problems' really had money problems. Husband would argue with wife because they were naive in managing their money, and it turned out the one who could help them best was not a psychiatrist but a banker. The agency got the part-time services of a banker, and lawyer, to assist its caseworkers.

"You have to analyze each community by its own profile. You have to look at it in its totality, in terms of its health, happiness, and ability to adjust. In this way, you will see what the major gaps are and mental health may be third or fourth in the priority of needs.

"In poor, disorganized communities, we must reach out to patients in need rather than sit and wait for them to come to us. Some need psychiatric help, some need welfare help, but don't know how to find it in our complex society. We are thinking about planning a role for a new kind of professional called an intervener. This would be someone living in the community who is a resource for disorganized individuals. He would have a variety of skills, he would know about welfare, rehabilitation, and employment programs as well as mental health programs. His salary might be shared by many agencies.

" 'PRIMARY PREVENTION' A GOAL

"I would like to build a primary prevention system—it may take us many years to do it—but this is our goal, not only to pick up the people who have clearly cracked up, but also to prevent crackups that occur because there is no one on the spot to help. There are many clearly indicated stressful situations: Death, pregnancy, childbirth, illness, accidents, loss of job, financial reverses, and so forth.

"Someone ought to intervene just to make sure that people in these situations do not suffer beyond their emotional endurance. For example, there could be a hookup between members of our staff and a minister or public health nurse so that when a man dies leaving a widow and young children someone visits her. The nurse might ask her whether she has a family to help her, whether she needs someone to help care for the children while she is in mourning, whether she needs legal aid * * *. We are living in a highly exploding technological society which is taking away our ability to cope with stress. And we pay a terrible price for it. We need to build in some strengthening resources. And that comes in the field of mental health.

"THE 'IMPLIED CONTRACT'

"We have developed a concept called implied contract to initiate mutual responsibility for patients. In essence, this means when we accept a referral from another agency, we ought to expect that agency to cooperate in treating the patient—and in maintaining his health afterward. Frequently, the mental health department is seen as a dumping grounds for troublesome persons. We need to tell communities that these people are not just our patients but their citizens, and that we expect them to retain a meaningful role. We can't hold them to it, but it is a sort of gentlemen's agreement.

"For example, when a school sends a child to one of our clinics, the implied contract could be that the school doesn't suspend the child. Another could be that we expect teachers to know what constitutes a disturbed child. They have no trouble spotting the aggressive, noisy, unmanageable child, but they frequently don't recognize the quiet, depressed one as also being a client for referral. Of the latter, many teachers rather blandly say: I wish I had 35 more like her. She's so quiet and she sits and doesn't make any noise.

"And we can say to communities: You have schools, churches and swimming pools. Why can't our patients use them? Why should we create an island in the community by building separate, duplicate facilities? This is a form of segregation which is destructive to the patient's concept of being an individual * * *. Another thing—the doctors, teachers, ministers, all the people who should be coming into our institutions from the outside to continue their relationships with patients—we should invite them to do so.

"Maybe when a man comes in for treatment we can call his employer and say: Look, he's been having a rough time. He's going to have a rough time during the next 5 or 6 weeks. If you know this and we can work with you, we can keep this valuable man on the job.

"The employer may be ready to fire this man, but someone talking to him with authority from the clinic or hospital may save his job. It would be a damaging thing if the employer fired him just before he was ready to get out of treatment. We should try to cover all angles to make a patient's return to the community more effective.

"The implied contract might be extended to a patient's family. The family members can get some insight into his problem, learn enough about him so that they don't add to the stress of the situation, accept a specific, commonsense role in dealing with him during treatment, and stand ready to take him back when he has improved. Under consultation with staff members, they can become co-therapists. Just visiting and sending clothes isn't enough * * *. Frequently, families aren't concerned about the patient once they get him off their backs. They have tolerated his illness so long that they are fed up and believe they have no more love to give him. But even to these we should say: It is true you have had a difficult time. But what can we do now to help you—not only as members of his family, but as individuals?

"NOT ALL CAN BE CURED, BUT * * *

"I think we can return patients earlier to the community, with the mature realization not all can be cured. The community expects every patient who goes out of the community for psychiatric treatment to stay out or come back a totally cured and competent individual. I think this is an unreasonable expectation. And the community is not alone in it. Sometimes the expectations of a therapist both in terms of what he should do for the patient and what the patient should do in order to become better are unreasonable.

"A man who has been operated on for cancer—if he last 5 years without a recurrence—is considered statistically cured. But if a man who has been out of the mental hospital 10 years breaks down again, people say: Oh, oh. There goes that mental patient again. They may not see this as an entirely different episode produced by different stresses. A diabetic may see his doctor every month and take insulin every day, and this is accepted. Yet, when a patient who has left a State hospital sees a psychiatrist once a month and takes a tranquilizer every day, this is regarded as an unfortunate failure.

"THE WIDE, WIDE WORLD

"I think we have a role in social action which can lead the mental health worker into such areas as poverty and welfare, unemployment and education, crime and punishment, slums and urban renewal, and general health and safety—where he rubs elbows with such people as public administrators, economists, politicians, lawyers, city planners, political scientists, businessmen, religious leaders, educators, and social scientists. There is much beyond mental health that is important to us.

"Mental health professionals should enter these areas as resources and as students so that they can contribute to and learn about their communities. If they don't, the facility they represent will be an island which is misused and they will be people who are misunderstood * * *. They too are citizens of the community, and I hope they are enlightened ones.

"But social action should never be confused with mental health planning. It is easy to be an expert in the land of the blind and it is seductive to be asked to lead in an area outside one's competence. Frequently, groups want to turn over a chairmanship to a psychiatrist or psychologist when the job is social planning, not mental health, and when there are people in the room who don't have a doctorate, but who are better qualified * * *. In such cases, we should contribute, not lead—take a seat on the committee, not the chairmanship. Of course, sometimes the chairmanship is appropriate."

Governor KERNER. I appreciate the opportunity to appear on behalf of this bill because if it is enacted it will bring us much closer to achieving the goal of making community-based mental health services available to all citizens.

When I speak about community-based services, I am talking not only on the basis of theory and abstraction, but also on the basis of a program underway toward personal realization of the value of these kinds of mental health services.

We in Illinois have been convinced for a long time of the need for a change in the way mental health services should be delivered to our citizens.

We recognized several years ago that it did not make sense to continue to send patients to large and remote State hospitals.

May I say this was recognized initially by that great Governor of Illinois, Gov. Ralph Gill, back in 1893 when he did not condemn large institutional hospitals but thought it would be the better sense of wisdom, certainly, to establish cottage-type institutions where more personal attention could be given.

I think this is the touchstone, too, of what we are talking about, of staff and services.

In 1961—2 years before the passage of the Community Mental Health Centers Act—the Illinois Legislature authorized the creation of zone centers throughout our State. There will eventually be seven such centers. The first, the Charles F. Read Zone Center in Chicago, will begin operating in just a few months.

I would like informally to issue an invitation to all members of this committee to visit us on that occasion, and to follow it with a formal invitation, since it is the first of this type of facility to be opened in the United States. The others will be in the cities of Rockford, Chicago—where there will be two—Peoria, Springfield, Decatur, and Champaign.

All of these institutions are under construction, and the last will be completed within a period of 2 years.

The basic theory of the zone center concept is to provide intensive, short-term care in an environment designed to keep the patient in his own community. In a real sense we intend the zone centers to be demonstration facilities—demonstrations of excellence in program and method so that the community can fill in the program gaps and complement our efforts.

A governor enjoys nothing more than pointing with pride to accomplishments within his own State, and in addition to the zone centers, I would like to mention these other developments related to our Illinois mental health program that make us especially proud.

In order to be effective, mental health service must be closely coordinated with other health programs and with other activities of State government. When we were beginning to think about the zone centers, we decided to establish uniform service regions throughout the State for all our health and welfare agencies.

Accordingly, I issued an executive order effective July 1, 1963, to provide uniform service areas for the department of mental health, the department of public health, the youth commission, the division of vocational rehabilitation, the Illinois Public Aid Department, and the Division of Services for Crippled Children of the University of Illinois.

All of these agencies now have regional offices in the same central cities, where the zone centers are being constructed.

In most of these instances these facility services will be available in the immediate adjacent lands of the mental health hospitals, so we can properly coordinate them and discommode the citizens as little as possible.

This move is already leading to more effective service to patients requiring help from several State programs.

We are proud also of the establishment, in 1961, of a separate department of mental health in the State government, to replace the former department of public welfare.

The department of welfare was about 85 percent mental health problems and 15 percent social service problems.

Dr. Francis J. Gerty, a leading psychiatrist and former president of the American Psychiatric Association, was its first director. He has since been succeeded by Dr. Harold M. Visotsky, who has established an outstanding national reputation.

A third accomplishment, and then I will stop boasting for a moment. In 1963 a State law was enacted permitting local government units to tax themselves for mental health services by submitting a proposal for a referendum at a general election. Last November I was gratified to see that of the five mental health referendums proposed, four passed.

But these are accomplishments that have already been achieved. We cannot be forgetful of a future which is rapidly closing in on us. I mentioned that the first of our zone centers will open in April. Thereafter, during the coming biennium, which begins on this July 1, all of the other centers will open. Yet opening them implies a staff to carry out the treatment program.

Therefore, in accordance with the request of Dr. Visotsky, I intend to budget, and I have the assurance of our budgetary commission, which is a legislative commission in the State of Illinois, an additional \$96 million increase for mental health during the next 2 years.

Most of this increase will be used to provide additional staff at our State hospitals and some 2,785 employees at the zone centers.

I have told you about our recognition—before Federal legislation was enacted—of the need for community-based mental health services and of how we have revamped our State machinery to help assure a program of services that will more truly meet the mental health needs of our citizens.

When all of these mental health clinics are completed, no citizen of Illinois will be more than 90 minutes away from these facilities, and we have just begun the completion of the first phases of these institutions.

I shouldn't say institutions. Clinics, I think is more aptly the word.

Why, then, am I here today to speak in favor of Federal legislation to assist in the initial staffing of community mental health centers? How would we in Illinois, with our program already developed beyond that of many States, use the Federal funds?

The answer to us is clear. The State-financed zone centers, which we expect to have in operation in the near future, form only the basic elements or the foundation of a mental health structure.

The zone centers will serve as a vital resource and backstop to local community centers, providing the leadership for an enlarged community-based effort.

As this matures, our zone centers will fade into the background and become members of a coordinated network.

In the years ahead, the local communities will need to exert a very strong effort through their mental health agencies and related resources. The efforts will have to combine resources and talents from the public and private sectors.

This community effort will be facilitated through the funds made available under the Community Mental Health Centers Act of 1963 and—hopefully—through funds to aid in the initial staffing of centers built under that act or otherwise providing a comprehensive range of mental health services.

One of the most frequent questions put to me, and I know it is one of the questions that concerns you, is: "Where will we get the people to staff these efforts?"

If the opportunity to serve in a vital, growing mental health program is made available, the professionals can be found. In Illinois during the past 4 years, we have more than doubled our psychiatrists and psychologists in public service, and tripled the number of social workers.

I would like to add that in addition to this, we have been delighted with the number of local service communities that have joined in these efforts, to give these people the feeling of being part of the community and not an isolated, ill people that should not move in the general community.

We feel the local communities will be able to do the same if they can obtain Federal support for the initial phase. However, the manpower problem must be dealt with on all fronts, educational by redefinition of professional roles, and utilization of community resources on a part-time basis.

In other words, gentlemen, the Federal funds will help the States and communities to begin the job that needs to be done. That is why we are encouraging local communities in Illinois to develop programs which will make them eligible for funds available to our State.

I think the question was asked by Mr. Younger, I believe, as to whether these funds, which would come to Illinois, would be used for the State. In Illinois, 100 percent of these funds would be sent to the local community.

We wish, however, the funds to go to the State of Illinois in order that we may be certain that the program that they have fits part and parcel into the State overall program. Certainly, we wish to establish minimal criteria so the money will not go to waste.

We recognize that the safeguards of the Federal legislation and the program standards form the basis for truly comprehensive mental health programs. So I have instructed the Illinois Department of Mental Health to lend to local groups every assistance in planning their programs to qualify under the law.

We are also making use of available Federal funds to upgrade the quality of care in our State hospital system. At the same time that

we recognize the promise of the zone centers, we cannot forget that the State hospitals are a major element in our mental health program.

In Illinois, some 34,000 persons are resident in these facilities on any one day, and last year we spent nearly \$74 million for maintenance expenditures in the hospitals.

May I say I am pleased to say in 1961 our residency was about 50,000 so that the effect of our staffing and our program has already reduced the number of full-time residents in our State hospitals.

Only three States—California, New York, and Pennsylvania—have spent more than Illinois.

We are now engaged in drastically altering the programs of these State hospitals, and some Federal aid has been available to us in this effort. At Manteno State Hospital, for example, we have a \$292,300 hospital improvement project grant from the National Institute of Mental Health to reduce overcrowding by accelerating the movement of elderly patients back to their communities.

At both Jacksonville and Kankakee State Hospitals we have a \$1,235,000 in-service training grant from the National Institute of Mental Health to intensify the training of psychiatric aids and broaden their role.

Funds that will help our mental health program also have been made available under other Federal legislation. Under the Area Redevelopment Act, a total of 166 persons had enrolled in a psychiatric aid training program at Anna State Hospital as of December 1964.

Fifty-nine of these people have already been graduated and 29 have been employed by the department of mental health.

I presume you would like to know what has happened to the other people. They have gone to private institutions and other hospitals. So I say this program has not only helped the State institutions but it has helped the hospital facilities throughout the State of Illinois and other States adjoining us.

At Chicago State Hospital, 213 persons had enrolled by December 1964, for housekeeping services training under the Manpower Development and Training Act. Of the 147 already graduated, 66 have been employed by the department of mental health and another 56 by private hospitals.

In Illinois, clearly, we are not afraid of Federal aid. Even though our Federal Government is one of the largest and most powerful governmental systems in the world, it is, indeed, a democratic system.

"Big government" can be "great government" as well, when it is ever mindful that it is the man, rather than the state, whom it serves.

I think the mental health planning effort now going on in all the States furnishes us with a good example of government joining hands with community volunteers to accomplish a worthwhile goal.

Mental health planning committees in all the States are made up in large majority by men and women who, as concerned citizens, are bringing to this planning effort their expert knowledge in the fields they know best.

They include in their ranks representatives of the professions, business, industry and citizens groups—people in all walks of life and from the towns and counties, as well as urban centers.

The result of their efforts shows that the community-based constellation of mental health services we are working to bring about will be more widespread and more realistically founded than would have

been true if this were planned solely by Government officials, at whatever level.

The mental health planners are taking cognizance of the social change and evolution going on in this country. The shift of population to urban areas poses adjustment problems for nearly everyone involved.

Disruption of a way of life can bring serious stress, especially for those who are already emotionally unstable. As the population shifts and expands, new problems are created for schools. There are outbreaks of violence among races, there is economic dependence and increasing illegitimacy.

Those who are planning community mental health programs must plan them so that the services will be appropriate to our fast-changing American society.

A comprehensive mental health program must be concerned with the stress-producing factors in the community. The mental health program must be a program in which many services are readily available—treatment services, consultative services, and educational services to individuals, private and public agencies and organizations shaping the environment of each local community.

The services must be available to the patient where he lives and when he needs them, and to the community per se.

Gentlemen, I would like to leave you with one last thought. It has to do with what we have learned from a year and a half of mental health planning.

We have learned that the time for action is now. It is imperative that we reverse some of the trends that have become all too obvious as we have studied all States' mental health needs and resources.

For example, the number of children and adolescents being admitted to State mental hospitals is increasing rapidly. That was one of the things that shocked me while I was sitting in the mental health court as one of the adjuncts of the county judge's responsibility, to see psychotic youngsters, I didn't say adolescents or adults, psychotic youngsters appearing before that court who were 12, 13, and 14 years of age, who were unknown, shall I say, previous to the middle 1950's.

This is just one of the things that is becoming so obvious. If the current trend continues, by 1970 the number of children and adolescents in these institutions will be more than double the number of 1960.

The situation is more urgent now than when the Community Mental Health Centers Act was passed in 1963. That is why I am asking passage of this bill, which will help our idea of community-based services become a reality more rapidly.

I would like to close with just a paraphrasing of an old Dorothy Parker statement in reference to candy and liquor, if I may be so bold. I think buildings are fine, but believe me, staff is quicker, to solve the problem.

Thank you very much.

Mr. FRIEDEL. Thank you, Governor, for a very fine and informative statement. I want to congratulate you for having the foresight to start back in 1961 in Illinois on these zone centers. We have a very able Congressman from the State of Illinois, our ranking member of the other side of the aisle.

He may proceed to question you first.

Mr. SPRINGER. Mr. Chairman, thank you very kindly.

Governor, may I say it is an excellent statement. I have long known of your philosophy in this field. May I come back to one point? Dr. Visotsky will head this up and you will then have regional centers?

Governor KERNER. We will still maintain our State institutions. We will probably always have them.

Mr. SPRINGER. That will consist of the Jacksonville, Manteno, Kankakee, and Chicago?

Governor KERNER. Are you talking about mental health centers?

Mr. SPRINGER. Mental hospitals?

Governor KERNER. We have some 13 of them all the way from the Chicago State Hospital all the way out to Elgin and Peoria, down to Anna on the south, and East Moline.

Mr. SPRINGER. That would be 13?

Governor KERNER. Thirteen State hospitals.

Mr. SPRINGER. How many zone centers do you have?

Governor KERNER. We have seven zone centers.

Mr. SPRINGER. And those will extend from Chicago. What will be the southernmost one?

Governor KERNER. The southeasternmost one is at Springfield.

Mr. SPRINGER. That will be the southeasternmost of the seven zone centers?

Governor KERNER. Yes. But there would be Springfield, and then, of course, we have strung off to the east of Springfield the adult facility at Decatur, the children's facility at Springfield.

We have, however, some facilities, one which was completed last year, the Centralia hospital, which will have some mental health facility; and an additional children's facility, a research hospital at Harrisburg, which will be completed very shortly.

Dr. VISOTSKY. We have eight zones, Mr. Springer. We have divided the State into eight zones. In six of these zones we are building seven mental health centers. The mental health center is not only responsible for community mental health but for integrating treatment resources for any of the State hospitals or mental health clinics that fall into that zone. What we have done is actually decentralized the departments of mental health so that the zone director is essentially a commissioner of mental health for a smaller, more manageable area.

Mr. SPRINGER. How many clinics will you have in each zone?

Governor KERNER. We will have seven clinics, in this portion of the program, but not per zone.

Mr. SPRINGER. How many clinics will you have within the zone?

Dr. VISOTSKY. There will be one zone center. That is a clinic.

Mr. SPRINGER. That is a clinic?

Dr. VISOTSKY. Yes.

Mr. SPRINGER. By saying there are seven zones in the State of Illinois, no one will be more than 90 minutes from a zone center; is that correct?

Dr. VISOTSKY. That is correct.

Mr. SPRINGER. Do you anticipate anything below the zone center?

Governor KERNER. Yes; we do. As a matter of fact, right at the present moment, because we have encouraged local community-based clinics, there are already operational at the local level 50 mental

health clinics, which are operated by the local community with matching funds from the State program.

Mr. SPRINGER. What you have in effect done is by statute allowed—is it each county or each area?

Governor KERNER. It would depend upon the local discretion, whether it be city, township, county or bicounty.

Mr. SPRINGER. The organization may set itself up within a taxing body, is that correct?

Governor KERNER. That is correct.

Mr. SPRINGER. You may include a county or a township or several cities, to get sufficient support to maintain that; is that correct?

Governor KERNER. That is correct.

Mr. SPRINGER. Are these administered by Dr. Visotsky?

Governor KERNER. No; they are administered by the taxing body.

Mr. SPRINGER. What is your correlation with those?

Governor KERNER. We provide moneys for them and supervise their program. In other words, they must meet minimum criteria before we will grant moneys to them from the State mental health fund.

Mr. SPRINGER. What percent of the money do you grant to these local bodies, who tax themselves for this purpose?

Dr. VISOTSKY. It is a sliding scale. It will range anywhere from 30 up to 78 percent in southern Illinois.

Mr. SPRINGER. In other words, this is discretionary upon the amount of local tax funds they can raise under this?

Dr. VISOTSKY. In part. It is also discretionary on the part of services they provide, and the kinds of staff they can provide for those services.

Mr. SPRINGER. Would you repeat again, so that I get it how many areas or communities in Illinois have already chosen to tax themselves to raise some local clinic?

Dr. VISOTSKY. During the past election there were four such communities out of five.

Mr. SPRINGER. There were five that asked for the referendum and four of those succeeded?

Dr. VISOTSKY. Let me explain further. There are 50 other communities, Mr. Springer, that have already raised money by voluntary contribution, not by a tax base, to whom we gave a grant-in-aid to match their efforts.

There are two ways of raising funds.

Mr. SPRINGER. When that is done through a private effort which you have mentioned, is that supervised by a municipal body?

Dr. VISOTSKY. No; it is usually supervised by a board, usually the mental health association of that particular community.

Mr. SPRINGER. They have primary supervision?

Dr. VISOTSKY. Right.

Mr. SPRINGER. Is that under your standards?

Dr. VISOTSKY. We set minimal standards for granting funds.

Mr. SPRINGER. How many of these centers did you say there were?

Dr. VISOTSKY. There are 50 such clinics.

Mr. SPRINGER. How far south do they go?

Dr. VISOTSKY. That goes as far south as Anna, East Moline. I think Anna is probably the farthest south.

Mr. SPRINGER. Is that the bottom of it? Is that the lowest rung?

Dr. VISOTSKY. The clinics are the lowest rung; that is correct.

Mr. SPRINGER. Therefore, you start at the bottom by either a local taxing body or a private mental organization group. Then you would work on up through the State hospitals, they would be at the top. Let's take the intermediate quickly. The local taxing body or local private is first. What is your next level?

Dr. VISOTSKY. The State hospitals. The clinics supersede the whole thing. They are in charge of coordinating all activities for a particular zone.

Mr. SPRINGER. The next jump would be the State hospital?

Dr. VISOTSKY. That is correct.

Mr. SPRINGER. There are 13 State hospitals.

Dr. VISOTSKY. That is right. In some zones there may be two or three State hospitals. They would be responsible to the zone centers.

Governor KERNER. If I may at that point interrupt, I didn't complete the number of other institutions we have at the State level.

We do have 5 mentally deficient institutions as well as the 13 State hospitals.

Mr. SPRINGER. What do you mean by "mentally deficient?"

Governor KERNER. Such as the hospitals at Lincoln, Dixon, and Centralia. I do not include those as mental health institutions. We have a dividing line with reference to them.

Mr. SPRINGER. How many are there, five?

Governor KERNER. Five; yes.

Mr. SPRINGER. Are those for children?

Governor KERNER. Not children, but mentally defective individuals.

Dr. VISOTSKY. The average age is 18.

Mr. SPRINGER. There is generally not recovery in that area?

Dr. VISOTSKY. There is rehabilitation.

Mr. SPRINGER. But not recovery?

Dr. VISOTSKY. No.

Mr. SPRINGER. Then this makes a total of how many State institutions in this field, not counting the local taxing bodies and the local private?

Dr. VISOTSKY. Thirteen mental health institutions, plus 5 institutions for the mentally deficient, plus 7 zone centers, for a total of 25.

Mr. SPRINGER. Plus how many did you say there were in the private and local field?

Dr. VISOTSKY. Fifty mental health clinics.

Mr. SPRINGER. Making a total of how many?

Dr. VISOTSKY. If you want to add them, it is 75. You see, they are integrating bodies.

Mr. SPRINGER. I understand. I was trying to find out how many agencies in the State of Illinois were working in this field.

You have given me that. Thank you very much.

Mr. FRIEDEL. We also have another distinguished gentleman from the great State of Illinois, one of our new Members—Mr. Ronan.

Mr. RONAN. I have no questions, Mr. Chairman, but I would like to compliment the Governor on his excellent statement. We in Illinois have been very proud of Otto Kerner as our Governor, especially the work he has done as Governor and prior to that as county judge in this field. We feel he has been a real pioneer in this very important field. We in Illinois like to think that Governor Kerner started out the program that the Federal Government could well follow as its model.

I want to thank you for coming, Governor.

Governor KERNER. Thank you very much, Congressman.

Mr. FRIEDEL. Mr. Dingell?

Mr. DINGELL. Governor, it is a privilege to see you again, and to commend you on a particularly fine statement. I want to commend you particularly for the work that you are doing in this very important field. I also want to commend you, particularly, for one statement which you made in your fine statement. That is where you said:

In Illinois, clearly we are not afraid of Federal aid, even though our Federal Government is one of the largest and most powerful governmental systems in the world it is indeed a democratic system.

Big government can be great government.

This is something I have always believed. I have heard too many people come to Washington, both inside the Federal Government and inside the State governments and outside the State governments, who greet the Federal Government as though it were some alien organism or something completely out of keeping with our ancient traditions in this Nation of ours.

I think you have expressed something that a good many of us need very badly to listen to. I commend you for it.

Governor KERNER. Mr. Dingell, if I may refer back to my experiences as county judge in the mental health court, it breaks our heart to sit there in that court and determine whether an order should be entered against an individual who is not a citizen of the State of Illinois and know when you sign that order that individual will go to one of our State hospitals for a short stay and be transported back to another State that has no facilities for another hearing.

Chicago, because of its geographical and transportation center, brings to that tremendous, complicated, and sophisticated community people who get lost emotionally. There is no way, under the present law, that we can help them, really. I am hoping that the services that we can provide for those people who are citizens of Illinois will also be available to citizens of other States.

May I say that we in the Midwest States particularly recognize the fact that geographically we may have facilities that are better located for communities of other States, that are more readily available to give treatment, than going to their own.

We are attempting to work out such arrangements on a bistate basis, to provide facilities for people, not only because they are residents of the State of Illinois or citizens of Illinois, but provide this help for all people who need it.

Mr. DINGELL. Thank you very much, Governor.

Mr. FRIEDEL. Mr. Younger.

Mr. YOUNGER. Thank you, Mr. Chairman.

I do want to congratulate you, Governor. I am glad you have put in your remarks that there are only three States who have spent more, and one of them is my home State of California, but also I realize that spending money alone is not the only criterion by which this work can be judged.

Governor KERNER. Hear, hear.

Mr. YOUNGER. This bill provides an open end appropriation. I am not sure the committee will buy that. In case there is a limitation on the appropriation, the question arises, "How are we going to distribute this money to the various States as we do, for instance, in the Hill-

Burton, so that the States do get an equitable share of this staffing money?"

You mentioned there are other States that are not as enlightened as yours, and you hate to send patients back to a State that is not. We must lend encouragement to those States by this legislation.

Have you any suggestions as to what would be a good method of limiting this money so that each State will know that they are going to get some of it?

Governor KERNER. Well, of course, I would say that the same rule that is applied normally here by the Federal Government in granting funds to States and communities on the standard of planning and program is important. Money can be wasted, but if there is no proper planning or program, the money will be wasted.

We in Illinois, I say, ought to feel upset because we haven't gotten all the money we thought we should have gotten because we are so far ahead of the program. We don't object to that because we can use what we get to further expand, but at least I think the primary program must be, What is your planning? What is your program? and if it meets the minimal standards or criteria, then to grant a sum.

Mr. YOUNGER. I think one of the most technical programs and one that has met the need best is the Hill-Burton. In that, the States do have a certain amount of money definitely allocated to them. Do you believe that in this program, if the limitation of money is placed in this bill, rather than an open end authorization, we should follow something similar to the Hill-Burton allocation of funds so that there will be enough left to take care of other States?

Governor KERNER. Yes, I would think such a plan could be used. I would suggest, too, that if a proper plan or program had not been presented within a certain calendar time, that that money be made available to those other States that have a proper program and plan that is acceptable and moving ahead.

Illinois has been very fortunate in National Development and Defense Training Act funds, and this has helped lower our unemployment rate in Illinois to almost the irreducible minimum, because we were able to use funds allocated to other States, but not used. But I think certainly there ought to be some top on this.

Let me say, as a Governor, I have to worry about how much I have to raise, and I would not like to be put in the position of keeping on raising and raising and raising without a ceiling. Yes, I think there should be a ceiling.

Mr. YOUNGER. Thank you very much.

Mr. FRIEDEL. Mr. Rogers?

Mr. ROGERS of Florida. Governor, I have enjoyed your statement and I appreciate what your State has done. As a matter of fact, Dr. Visotsky, as I recall, testified before this committee when we were considering the original bill, and I remember particularly his testimony about what was being done in Chicago in this community approach. It has been helpful to me, I know, in considering the legislation that set up our community health program.

Do you pay staffing in your grants to the various communities?

Governor KERNER. We don't want any of our funds used for building. If I had only a limited amount of money and I had a choice to make of buildings or personnel, I would prefer to put it on personnel. Personnel can be useful out in an open tent, if you wish.

Mr. ROGERS of Florida. So your money in the State goes to the staffing?

Governor KERNER. Yes.

Mr. ROGERS of Florida. You have doubled your psychiatrists and psychologists, I see, in public service.

Governor KERNER. Yes.

Mr. ROGERS of Florida. Have these personnel come from your State or have they come from other States?

Governor KERNER. They have come from all around the world. We even have some people of outstanding ability from West Germany.

Mr. ROGERS of Florida. I was wondering if this is creating some shortage in other States.

Governor KERNER. No, we have trained many of our own. I think actually most of the staffing money that you seek to provide for this fund will have to be for development. They are in inadequate numbers today. Let's recognize that fact. They are in short supply. I would hate to see the various States bidding on the basis of dollars.

Mr. ROGERS of Florida. This is one of the problems I am concerned with as we go into this problem. For instance, we have psychiatrists and psychologists in our veterans' hospitals. I am concerned, too, about the pay scale. If we come in with a tremendous program here in some areas we may, for instance, drain the Government hospitals of psychiatrists.

This may not happen, but I think it is something that we should consider. I wonder if you could tell me in your regional clinics, for instance, how many psychiatrists you require?

Dr. VISOTSKY. Are you talking about the zone centers?

Mr. ROGERS of Florida. Yes.

Dr. VISOTSKY. These are larger centers than the Mental Health Act. We would require anywhere between 7 and 12.

Mr. ROGERS of Florida. And this is true in each of your zone clinics?

Dr. VISOTSKY. That is correct.

Mr. ROGERS of Florida. A minimum of 7?

Dr. VISOTSKY. Yes. I would point out, in addition to this, that we spend \$30 million every 2 years, during the biennium, in a research and training program. We have trained more than 70 percent of the staff that we have hired and kept them. Formerly, they used to leave our State and go to Mr. Younger's State, or perhaps even to your State. We have kept them in Illinois now.

Mr. ROGERS of Florida. In your community mental health facility, what would be a normal requirement for psychiatrists? Do you base these generally on about 100,000 population?

Dr. VISOTSKY. Yes.

Mr. ROGERS of Florida. How many psychiatrists would you think would be required?

Dr. VISOTSKY. Again, it depends on the services, Congressman.

Mr. ROGERS of Florida. Suppose you handle the five services that we talked about, on the inpatient and outpatient basis.

Dr. VISOTSKY. I would say for a community of 100,000, I would expect anywhere from 3 to 5, depending on how you use them. A good many of them will be doing consultation to agencies so the agencies can do their job much better and prevent the inflow of patients to the center.

Mr. ROGERS of Florida. Let me ask you this: Is it your plan in Illinois that these psychiatrists devote all of their time to these community facilities, or do they have a private practice as well?

Dr. VISOTSKY. We encourage people to have a private practice. We also hire people on a part-time basis. This is a field in which there is a manpower shortage, and psychiatrists in private practice should be encouraged to work in our facilities and, in turn, our psychiatrists who are full-time should be encouraged to have a part-time private practice. It not only helps the community, but it gives them a broader approach to the problems of the community.

Mr. ROGERS of Florida. What is your pay scale in Illinois for your psychiatrists, from the beginning up to the top?

Dr. VISOTSKY. It ranges anywhere from \$15,000 to \$26,000.

Mr. ROGERS of Florida. If they have a part-time practice, is this taken into consideration in their salary?

Dr. VISOTSKY. No, sir. The only thing that is taken into consideration is how much time they work for the department of mental health. Anything beyond that is their own business.

Mr. ROGERS of Florida. In other words, you have so many hours that you expect them to devote to the clinic or the zone center.

Dr. VISOTSKY. That is correct.

Governor KERNER. May I point out, Congressman, this puts us in a competitive position without paying the dollars.

Mr. ROGERS of Florida. These are some of the problems that I was concerned with, and how this would actually work. I would think many of the communities will have to call on the practicing psychiatrists to come in and help staff the centers. Is this being done and how does it work?

Dr. VISOTSKY. This is being done and it works well. I think with the community interest in mental health, many of the private practitioners see this as a challenge to expand their horizons of treatment. Many of them are giving anywhere from 4 to 20 hours a week. This is quite appropriate. Some of them are extending their practice; whereas, they would work 50 hours a week, some are working 60 hours a week now.

Mr. ROGERS of Florida. And you pay them correspondingly for the time spent?

Dr. VISOTSKY. Yes, we do.

Mr. ROGERS of Florida. On an actual salary or on a consulting basis?

Dr. VISOTSKY. We pay them on a consulting basis, but it is based on a salary level.

Mr. ROGERS of Florida. And as to your psychologists, is there a great shortage of psychologists?

Dr. VISOTSKY. Yes. I would point out that in 1961 there were some 140 psychologists working for the State, and we had a freeze for 1961 and 1962. We now have 220. Most of those came from our own training programs.

Mr. ROGERS of Florida. What is your salary range there?

Dr. VISOTSKY. There is a new arrangement. It goes from \$8,000 to \$15,000, the top; \$18,000, I am sorry, for the chief psychologist.

Mr. ROGERS of Florida. Then I notice you train a great number of people as aids.

Dr. VISOTSKY. Yes. We have to maintain an on-going faculty, that is, the trainers. We can't use all the people we train and we feel

it is a privilege to turn some of the people we have trained with a certificate back to the community. This is another way of serving the community. If they are good psychiatric aids in the communities, chances are we will not have these patients dumped on us in a State hospital.

Mr. ROGERS of Florida. I want to thank both of you gentlemen for your fine statements.

Governor KERNER. I want to add something else. Dr. Visotsky is liable to hide his light under a bushel. I would suggest in the other States where they have programs comparable to ours that Dr. Visotsky is also a teacher, and this gives him the opportunity of interesting young students in our State program. If you would sit and visit with him, he would tell you that every week he brings a few students along with him to visit the hospitals and to sit with him as a director, to give them the challenge of the problems of mental health.

This has interested a great number of very talented young people into government service who otherwise, I think, might be lost to government service entirely.

Mr. ROGERS of Florida. Thank you.

May I just ask one more question? Do you use a psychiatrist or psychologist in an administrative manner, or do you have an administrator, as such?

Dr. VISOTSKY. There isn't a set policy in this, Congressman. We use the best man for the job. Ordinarily we don't find psychiatrists to be topflight administrators, but where we find they are, we use them as such.

Mr. ROGERS of Florida. I would not think you would want to tie him up with administrative details, but would prefer to use his medical knowledge.

Dr. VISOTSKY. There are certain positions of administration where knowledge of the psychiatric field is most important. In those instances, we look for administrative psychiatrists.

Mr. ROGERS of Florida. Thank you.

Thank you, Mr. Chairman.

Mr. FRIEDEL. Mr. Devine?

Mr. DEVINE. Thank you, Mr. Chairman.

Governor, I think you should be complimented on your fine statement, and the people of Illinois for going forward on their own in this great area.

Governor, you are in Springfield and you go before your Illinois Legislature with a state of the State message at the beginning of each session. With such a worthwhile program as this appears to be, I presume you also make recommendations on taxing and fund-raising procedures to the legislature on how they are going to raise the money to pay for this.

Governor KERNER. Yes. Unfortunately, I am the only one in the State that has that responsibility, apparently.

Mr. DEVINE. In support of the programs here, and I agree they are very fine, are you in a position to recommend to the Congress of the United States any new taxes that we should enact to pay for programs of this nature?

Governor KERNER. I have enough concern of my own. If, perchance, I were ever honored by being a Member of the House or Senate, I think I would be in a much better position to make a recom-

mendation. I am going to have to raise several hundred million dollars more for the next 2 years in my own State and that is consuming all of my time and my effort.

Mr. DEVINE. You certainly have my sympathy. I think you, likewise, perhaps, should send some to this deliberative body, because we also, in passing programs of this nature, must look to our budget to see whether or not they fit within the terms of the budget. We have operated the Federal Government for a great number of years, as you know, on a continuing and growing deficit.

Although I share the views in your statement that the Federal Government is not necessarily an ogre, my philosophy is not necessarily that of my colleague from Michigan, that the Federal Government can answer all problems of all people. But I think that you also know that we must stay within the bounds of reason so far as finances are concerned.

I would like to know how you, in the great State of Illinois, which is a prosperous State, can look at the Federal Government to get this magic money that first must be extracted from the taxpayers of your State and the others in the Union.

Governor KERNER. Let me reverse it. If you would let us have it, I wouldn't come here to ask for any. May I say in all seriousness, we at the State level wouldn't use one penny of this money. We are funding our own State responsibility. I throw that in off the cuff just because the question was asked earlier by Mr. Younger.

Every penny of this money that would be allocated to the State of Illinois will go to these local community mental health facilities, to seed and encourage them. Therefore, if we get the mental health program and problem taken care of at the grassroots, we, then, at the State level, will take care of those more severe cases they cannot handle at the local level. We will take care of our responsibility in our State.

Mr. DEVINE. There is only one other thing. You can't overlook that the same grassroots people are the same people we must go to to get our Federal funds from.

Governor KERNER. That is correct.

Mr. PICKLE. Will the gentleman yield?

Mr. DEVINE. Yes.

Mr. PICKLE. Pursuing this same point, as I understand it, the American Hospital Association has recommended that these mental health clinics be staffed, but on a matching basis between Federal and State. I assume this is with reference to matching. If I am incorrect, I would want to be set straight on it. But does that reflect the Hospital Association group of Illinois?

Governor KERNER. I wouldn't know. I would have to turn that question to Dr. Visotsky.

Dr. VISOTSKY. I would presume it was. The Hospital Association in Illinois is a member in good standing with the national association.

Mr. PICKLE. I don't know how my own State would feel about this. You assume that it ought to be matching, but you don't know.

Dr. VISOTSKY. I would assume so. They have made no such statement to me.

Mr. PICKLE. Thank you.

Mr. FRIEDEL. Mr. Kornegay?

Mr. KORNEGAY. Thank you, Mr. Chairman.

Governor, I would like to express my appreciation for your fine statement and congratulate you and the great State of Illinois on what you are doing in this field.

I have just a couple of questions. The first one you have anticipated; that is, whether or not there is to be found adequate, competent personnel to staff these installations. That question has come into my mind since we started considering this matter.

I know in my State of North Carolina, qualified and competent psychiatrists are almost as scarce as the American buffalo. I am glad to hear you say what you said that since 1961, by concentrating on the problem, by endeavoring to educate, train, and encourage, you have considerably increased the supply of competent personnel in the area.

Governor KERNER. Mr. Kornegay, a very excellent example, I think, is the concern that the people of the United States and the educators had back in 1948 when the first sputnik went up, and now we almost have an excess of certain people in this field.

Mr. KORNEGAY. That is quite true.

Governor KERNER. The old law of economics usually takes care of these things. If you create demand, the supply will be increased.

Mr. KORNEGAY. We passed this program in the 88th Congress, and the provision for staffing at that time was deleted from the bill by the committee. My thought is that the committee felt we would furnish the seed money, so to speak, to get the States started. It obviously has not quite worked that way, so we now have before us H.R. 2985, which provides for aid to staffing on a diminishing basis over a 4-year period, I believe 75 percent, 60 percent, 45 percent, and then 30 percent, or 4 years and 3 months. I think the 75-percent provision prevails for 15 months.

Is it your feeling that if this bill is enacted and you receive the benefits of that type of Federal money over a period of 4 or 5 years, that from that point on your State of Illinois will be able to carry the burden?

Governor KERNER. Yes, obviously. I don't think if we are in the position to carry the burden that we should get any more money.

Mr. KORNEGAY. I think that is a very encouraging statement to us.

Governor KERNER. The experience I have had with our program, which is really only 3½ years along on a 10-year program the comments that are made to me by relatives of individuals who have benefited from our program indicate that there is a growing desire to even increase the program, and the people are willing to assume the cost.

Mr. KORNEGAY. When you see the results, any reasonable man who is interested in his community is bound to be gratified by it.

Dr. VISOTSKY. Congressman, it takes a certain amount of time to gear to a program such as this. Let me give you an example.

In Galesburg there is a college called Knox College. They have now started a 4-year program for child-care workers at a bachelor's degree level. They will be turning out people to work in these various programs.

I am sorry Mr. Springer isn't here because he comes from the University of Illinois, and at that university we have programs now in which the newly enrolled class has 120 students in fields of clinical training for psychology, community mental health, and child-care workers.

Given this 4 years, we can begin to encourage our educational facilities to gear for this operation, just as we had to do for sputnik. It takes time. We know that there are communities who will not take the construction money because they are afraid that they can't handle both.

Mr. KORNEGAY. Thank you.

Governor, I have one final statement, and that is that I learned something new today and, of course, you do every day you come to these committee meetings. I am happy to know that the State of Illinois is interested in and is a part of King Cotton.

Governor KERNER. Thank you.

Mr. FRIEDEL. Dr. Carter?

Mr. CARTER. I want to compliment the distinguished Governor for his excellent program, and the forward-looking planning that has gone into this. If one understands the dangers that mental health affords our people at the present time, if one could see these children who are psychotic, they would go right along with this appropriation, I am sure.

I certainly think the State of Illinois is doing a wonderful job and has a good program. It is to be complimented. Thank you.

Governor KERNER. Thank you.

Mr. FRIEDEL. Mr. Van Deerlin?

Mr. VAN DEERLIN. Like Mr. Younger, Mr. Chairman, I am grateful to the Governor for pointing out the strides that my State has made. I am even more grateful to him for resisting the temptation to be facetious on this subject and perhaps explain why California needs to spend more on mental health. Many midwesterners would not be so charitable.

I wonder if Dr. Visotsky has discovered anything in this area of psychotic children? I am quite staggered by his information that there has been a doubling of children receiving this treatment. I am wondering if this is just a doubling of cases that are discovered and treated, or whether there is something that our society is not doing and that it should be doing in this direction.

Dr. VISOTSKY. I think it is a combination of both. One is that the stigma of mental illness is dropping off. Doctors have stopped saying to parents: "The child will grow out of it. Let's give him a couple more years." We also know that the pace of our society has speeded up tremendously. The family has become smaller, and the substitute for a mother is absent in many families.

We also know that we are not getting to children early enough. We really waited for them to get psychotic previously. We know that we can pick up certain situations now which we can pretty nearly define that, given the same situation, the same stress, the child will surely break down at some point in the near future.

I would say that many of our programs must be geared to early detection and prevention. This is where we have to put a significant amount of priorities. If we don't, I think whether you can find the money to help with such programs, or not, you are going to pay it out one way or another. You will pay it out in juvenile delinquency programs, in narcotic addiction programs. You will pay it out from one side of the pocket or the other. I say let's put it in prevention, early detection, and treatment.

Mr. VAN DEERLIN. That is a good statement.

Thank you, Mr. Chairman.

Governor KERNER. Mr. Chairman, if I may, we in Illinois realize we are on two different types of programs at one time. I am hoping that if we put enough effort on the corrective at this time, with greater effort on the preventive, then whoever follows me will never have to face the corrective phase. It will never exist.

Of course, this is the ideal, but at least the corrective phases can become known.

Mr. VAN DEERLIN. Thank you.

Mr. FRIEDEL. Mr. Callaway?

Mr. CALLAWAY. I would like to commend the Governor and Dr. Visotsky for a most outstanding and informative presentation. I have certainly learned a great deal. I was particularly impressed with the obviously sincere testimony that after the seed money, Illinois will be able to go on its own without further Federal aid.

Thank you.

Mr. FRIEDEL. Mr. Pickle?

Mr. PICKLE. No questions.

Mr. FRIEDEL. Mr. Satterfield?

Mr. SATTERFIELD. No questions.

Mr. FRIEDEL. Mr. Ronan?

Mr. RONAN. No questions.

Mr. FRIEDEL. Mr. Mackay?

Mr. MACKAY. I was particularly interested in a statement of the Governor about the referendum on local taxes. Does your constitution permit taxation for this purpose under the general health clause, you might say?

Governor KERNER. Yes; our constitution allows for it. However, statutorily we had to arrange that such a taxing subdivision might be established.

Mr. MACKAY. That is the question. We have too many counties in Georgia, but do you have multicounty taxing districts now?

Governor KERNER. Yes; in some instances.

Mr. MACKAY. I mean for this particular purpose.

Governor KERNER. I am not aware that we do for this purpose, but we have multicounty taxing districts of various kinds in Illinois. We have 102 counties, to begin with.

Mr. MACKAY. The question is, was the referendum in more than one county?

Dr. VISOTSKY. There are some plans for this next election for four counties to join together.

Mr. MACKAY. What is the nature of the tax imposed as a result of the referendum?

Dr. VISOTSKY. One mill per thousand.

Mr. MACKAY. Is this a real estate ad valorem tax?

Dr. VISOTSKY. That is correct.

Mr. MACKAY. It seems to me this is the great strength in your program because people will have to understand it before they vote on it. Once they commit their minds and votes to it, it has a much greater chance of success.

Governor KERNER. Yes, may I say we are most thankful to the private civic mental health groups which have shown the way, which then allows them to sell the idea to the electorate to adopt it as a responsibility of all the taxpayers in the area.

Mr. MACKAY. Thank you.

Mr. FRIEDEL. Mr. Gilligan?

Mr. GILLIGAN. Governor, I pursued this question yesterday with Secretary Celebrezze that I want to talk to you about.

The State of Illinois, as you say, has borne its own responsibilities in the field of mental health, particularly in the maintenance of your big institutions, the particular type of somewhat more than custodial care, and any money available under this program would be channeled directly into this community program.

Have you a suggestion as to an encouragement that might be written into this program that might prevent the States cutting back on their programs and ignoring their responsibilities and simply substituting Federal dollars for State dollars, as has happened in my own State of Ohio?

Governor KERNER. I think certainly the only preventive you could put in is that being suggested for the educational moneys, that if you cut back, you do not get any. This is a prohibition. If a State does cut back, it becomes ineligible. I think the language should be in there. I do not think that any State ought to take advantage of Federal moneys by reducing the immediate tax responsibility of its own citizens.

Mr. GILLIGAN. Thank you, Governor. I think that is a very practical suggestion.

Mr. FRIEDEL. Mr. Farnsley.

Mr. FARNSLEY. Thank you, Mr. Chairman.

As a mayor, the only time I ever came up to appear before the committee was to ask them to put money into research for mental health. This is spending money to save money, to keep these people out of the hospitals. It is a wonderful thing.

Have you ever been criticized for having socialized mental care in your State?

Governor KERNER. On occasion but I get criticized for many things that are completely unreasonable, so this doesn't bother me. If I had a tissue-thin skin I certainly wouldn't be trying to do the things I am trying to get done.

Mr. FARNSLEY. You are doing a fine job, Governor. Thank you.

Mr. FRIEDEL. I want to thank the Governor for his very fine statement. It has been very informative.

The committee will now recess until 2 p.m.

(Whereupon, at 11:55 a.m. the committee recessed, to reconvene at 2 p.m. the same day.)

AFTERNOON SESSION

The CHAIRMAN. The committee will come to order.

We are honored this afternoon to have another distinguished Governor to visit with us, and present comments and views on this legislation.

Governor Dempsey, two of your colleagues were here this morning and presented testimony to the committee on programs that we have. We understood that you were detained and you would be here. We are glad to have you with us now, and we would be very happy to receive your presentation.

**STATEMENT OF HON. DONALD J. IRWIN, A REPRESENTATIVE
FROM THE STATE OF CONNECTICUT**

Mr. IRWIN. If I may, Mr. Chairman, I would just like to introduce my Governor; we are very happy to have him with us. I would like to leave a statement of my own for the record.

The CHAIRMAN. We are pleased to have your statement and to have the Governor here.

(The prepared statement of Mr. Irwin follows:)

STATEMENT OF REPRESENTATIVE DONALD J. IRWIN

Mr. Chairman, I come before this committee today as an enthusiastic supporter of H.R. 2985, which provides Federal assistance for the initial staffing of community mental health centers.

It is the vital second half of the proposals of the Kennedy-Johnson administration for the construction and staffing of these centers.

It is to the credit of the 88th Congress that it enacted Public Law 88-164, which provided construction funds for these centers.

Now we must finish the job. We must make provisions for the initial staffing. I am firmly convinced that these centers will be only as effective as the professional and semiprofessional staffs they have.

Even Connecticut, which can hardly be classified as one of the poorer States in the Nation, cannot afford to staff the centers without assistance. The Federal Government, at least at the start, is the logical source for this help, as both Presidents Kennedy and Johnson have indicated.

Therefore, I urge you today to approve H.R. 2985, which would help us to help our own people. Thank you.

**STATEMENT OF HON. JOHN DEMPSEY, GOVERNOR OF THE STATE
OF CONNECTICUT**

Governor DEMPSEY. Thank you for permitting me to come by this afternoon.

I joined a group of my fellow Governors to come here and express our desires on a program that is very near and dear to our heart. And I am glad that you permit me to stop by after a few hours of testimony on the New Haven Railroad.

Mr. Chairman and members of the committee, I present to you today an urgent appeal from the State of Connecticut, which warmly welcomed the Mental Health Centers Construction Act of the 88th Congress, for the further help that is needed to do the job we know can be done to treat and rehabilitate the growing number of mentally ill persons.

We recognize that the care and treatment of the mentally ill is a State responsibility. But we ask now that there be a sharing of that responsibility so that Federal, State, and local governments, acting as a team, can pool their tax resources to provide the adequate facilities and professional skills needed to return the mentally ill to productive life.

In Connecticut, the humane treatment of patients in our mental hospitals is maintained at the highest possible level. They are well fed, well clothed, and well housed. Beyond this, however, they have a right to expect to receive the benefit of all the progress which science has made in recent years to ward the conquest of mental illness.

The buildings which Public Law 88-164 is helping us to construct will be only as good as the people who staff them.

Professional skills, admittedly expensive, are absolutely essential for the attainment of our goal of offering active, short-term treatment in the community.

Even in a wealthy State like Connecticut, State tax structures cannot now provide the salaries required to attract these skills into public practice. Local communities, relying chiefly on real estate taxes for revenue, are hard put to meet the increasing costs of education without assuming new burdens.

In Connecticut, with a population of $2\frac{1}{2}$ million, simply the maintenance of present health services will cost the State more than \$61 million during the coming biennium.

How, then will high-level programs be financed by local communities or nonprofit private agencies which will be seeking construction funds for mental health centers?

The Federal Government has today an opportunity to provide incentives to citizen groups and local governments to help their own people.

I would like to present an example of how this would work in my own State.

Connecticut's second largest city, with a population of about 150,000, has at present, no mental health facility except for a child guidance clinic and limited adult outpatient clinic service. This city sends about 600 patients a year to the State hospital which serves it, an institution situated about 25 miles distant.

Grateful for assistance provided by the Mental Health Construction Act, I have asked the Connecticut General Assembly to make sufficient funds available to construct a comprehensive mental health center in this city. The range of psychiatric services to be offered would include inpatient and outpatient care, day and night treatment, and consultative services to such groups and agencies as schools, general practitioners, the clergy, public health nurses, and family agencies.

Once this facility is built, it will have to be staffed by persons capable of providing the urgently needed services such as a health center is designed to give.

How can the staff come from our State hospitals? They have no personnel to spare.

We must attract into public service, on a full- or part-time basis, private psychiatric practitioners and young people now making career choices. To do this, we must be able to offer them adequate compensation for their years of training.

At the present level of salaries which States can afford to offer, we cannot attract new people into the manpower pool. Further, we cannot continue to compete with each other for the scarce personnel in the present manpower pool.

Nevertheless, community-based services for the mentally ill represent an essential element of human welfare. I know that the States, local communities, and citizen groups can be shown how urgently needed these services are and how deserving they are of support.

I appeal to you today to help us by sharing the initial costs of staffing.

The city which I described to you is but one of a number of urban centers in Connecticut where there is a need for mental health services.

And Connecticut is but one of 50 States struggling to assume the responsibility for providing these services.

Give us, I urge you, the team leadership that will help us to do our job better.

I am very grateful to you, Mr. Chairman, for permitting the Governor of Connecticut to be able to present this statement to you.

The CHAIRMAN. Thank you very much for your statement. We appreciate your appeal out of the experience that you have had as the chief executive of your great State. And we are glad to have you take time from your busy schedule to come by for this purpose.

You did mention that you were using Connecticut as an example of a State that was unable to provide the personnel for the staffing of these mental health centers. Did you mean by that that you do not have the finances to do it with, or did you mean that you do not have the personnel available to do it with?

Governor DEMPSEY. Just a little of both. We realize that this bill would first help us to acquire the very best possible people. I mentioned those who are thinking about making this a career. We can build the best institutions in the world, but if the people inside the institutions are not the best, of course we do not want them. We have a little problem, Mr. Chairman, in both areas that you refer to.

The CHAIRMAN. What brought it to my attention is the fact that if the State is unable to get needed personnel, because we are not attracting people to schools in order that they can be educated in this field, how would you think the Federal Government could do it?

Governor DEMPSEY. The program of attraction, Mr. Chairman, is a continuing program. And we find today that we like to think of the program as attracting, not competing. We would like to be able, first of all, to provide the best possible facilities. This always helps you when you try to hire people.

The CHAIRMAN. We tried to do that last year in providing the construction program. And I took quite an interest in it, and had some small part in it. And I am very proud of it. But I was concerned and I am more concerned now about the program not getting off center. I am afraid if it lags too long the program will not be fully realized. And we are going back to this old concept which I am sure you are experiencing in your State, and which we are experiencing in our State, of concentrating these people in one place within the State, and, very often, they are forgotten and left there just to while the time away. That, it seems to me, is an abomination, and should not be permitted.

I know in my State we have had a program—and it is partially federally supported—in which fairly young doctors are becoming interested. And I know, even in my district, three or four that have decided that they would take special training in the field of psychiatry. These young men have quit their training as general practitioners and have gone to this special training school which required—perhaps you are more familiar with it than I am—a period of study, after which, of course, they would be specialists in the field of psychiatry. And I think we are seeing some of that throughout the country. I believe that with facilities and joint efforts, and so forth, we might get more people who are interested in it.

We were short of scientists not too long ago. We made a desperate attempt in this county in order to meet our competition. Now, in our institutions and our educational programs, we see scientists come from everywhere, and it sometimes seems that perhaps we have more

people than we know what to do with in the field of science. But I am glad to see it.

So I would like to make this record to show that if we can do something to emphasize the needs to people looking for vocations to pursue, and professions, then we can have better results.

Now, this proposal, as you know—and you did not mention it in your statement—proposes a $4\frac{1}{4}$ -year program of assistance in staffing these institutions.

Governor DEMPSEY. Yes.

The CHAIRMAN. Now, as the chief executive of one of the great States of this Nation, do you fully realize and understand and subscribe to the fact that if it gets started, say, in the first 15 months, the Government provides 75 percent of the cost, and the next year 60 percent, and then the next year 45 percent, and then 30 percent?

Governor DEMPSEY. Yes.

The CHAIRMAN. It graduates out?

Governor DEMPSEY. Yes.

The CHAIRMAN. And during the fifth year the Government gets out of it altogether?

Governor DEMPSEY. Yes.

The CHAIRMAN. What I want to get from you is: Do you fully realize that this is the proposal, and you are accepting it on that basis, and at the end of the $4\frac{1}{2}$ years you will be able to assume the responsibility?

Governor DEMPSEY. Yes, sir. I look to this time, the $4\frac{1}{2}$ years in Connecticut as the transitory period, during which we will need this help and need it very badly. In the $4\frac{1}{2}$ years, we would be willing, of course, with the program set up and with the new facilities built to assume that obligation ourselves. This help now would be very, very well received by all of us.

The CHAIRMAN. Do you think there is any question as to whether or not the States could and would assume the full responsibility at the end of this period?

Governor DEMPSEY. Connecticut has always assumed that obligation, Mr. Harris. And I have no doubt in my mind that it will continue to assume it. This, of course, will help us, and any program that can help us in what is near and dear to our hearts we are going to support.

The CHAIRMAN. I am very glad to have this assurance. And I want to emphasize this, that this is a very vital part of the proposed program.

Governor DEMPSEY. Yes; it is.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

Were you here this morning, Governor?

Governor DEMPSEY. I was not.

Mr. YOUNGER. I asked the Governors in regard to this bill whether they preferred to have Federal money paid into the State directly then let the State more or less supervise the distribution of the funds rather than have the Federal Government allocate the funds and approve the applications and pay direct to the applicant. What is your position on this?

Governor DEMPSEY. Whatever the committee decides, sir. Certainly, we do not prefer one over the other, whichever would expedite

the program for us; whichever would help us in the program that is contained in this bill, we would be for. We could live with either arrangement, but, if a choice is provided, I would prefer the first one you mentioned.

Mr. YOUNGER. You are familiar with the Hill-Burton Act?

Governor DEMPSEY. Yes, sir, I am; we operate under it.

Mr. YOUNGER. And there is no provision in this bill for allocation of funds to States. And if we put a limitation in the bill rather than open end authorization, would you favor the protection of the States and an allocation of funds to each State so that the one State does not get it all?

Governor DEMPSEY. We would not oppose it for the program that we are undertaking in the State of Connecticut. Perhaps this might be a good formula.

Mr. YOUNGER. As I understand, the per capita wealth in your State is quite sizable, the wealth is about the highest of the 50 States, isn't it?

Governor DEMPSEY. Almost, sir. Second, I think.

Mr. YOUNGER. It always rather baffles me why the people in the States—and we have it in our own State in California—feel that the people would more willingly and gladly pay taxes to the Federal Government than they would to their own State. Now, why is that?

Governor DEMPSEY. I had the same question regarding the New Haven Railroad. I suppose, sir, that in a State itself, even one as small as Connecticut, there are so many obligations, education, mental health, mental retardation, the building of roads, and so forth and so on, that we look to this as a partnership, keeping in view the other many fine programs that you have made possible for us. Mr. Harris referred to one that he was interested in. And he did an outstanding job. We feel, very frankly, that if there is other help, the taxpayers in our State are willing to assume the obligation. I am sure if no bill comes at all we will still try to do the best possible job. But when this legislation was sent down here and put together we were very pleased, because it recognized a partnership between the States and the Federal Government. And we have participated in many of your programs, the Hill-Burton and many, many more. And I am not sure whether the people would rather pay taxes to one group or the other.

Of course, most people in public life tell me they do not like to pay any. But I would say, Mr. Representative, that it seems that we look upon this in Connecticut as a sort of partnership, if you will. We look to the Federal Government, and we are very happy and proud to cooperate with the Federal Government on any of these programs.

Mr. YOUNGER. But you do not want to lose control of the program in your own State?

Governor DEMPSEY. You know the word "control" has never bothered me as much as it bothers some in government. My only interest, sir, is that some day, please God, we won't have to come to this committee asking you for a cent for mental illness, because we hope that we will cure this with God's help forever. When that day comes, I will be the first to come down here and thank you and say, we are not asking you for a penny. But until that day, these people must have help, and I am going to ask it for them.

Mr. YOUNGER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Satterfield.

Mr. SATTERFIELD. No questions.

The CHAIRMAN. Mr. Devine?

Mr. DEVINE. No questions.

The CHAIRMAN. Mr. Gilligan?

Mr. GILLIGAN. No questions.

The CHAIRMAN. Mr. Broyhill?

Mr. BROYHILL. No questions.

The CHAIRMAN. Mr. Farnsley?

Mr. FARNSLEY. There is no reason you would know the answer to this, but you might. When was the first mental hospital built in your State?

Governor DEMPSEY. I do not have the answer in terms of dates. It was very many years ago. As you probably know, Governors ahead of me were very active in this program. Connecticut has been a leader in mental health.

May I just tell Mr. Harris this, because of the many years that he had devoted to this field. In the past several years in the executive mansion we have shown some beautiful paintings. We have had inquiries from all over New England as to where these paintings have come from. And we announced last week that these paintings are from our mental institutions. They are some of the finest we have ever seen. And we show them to exhibit the type of programs that we have in Connecticut.

I will be glad to get you that date. I can take a guess, but I will not.

(Governor Dempsey later gave the date as 1868.)

Mr. FARNSLEY. It is not important, thank you.

The CHAIRMAN. Mr. Harvey?

Mr. HARVEY. No questions.

The CHAIRMAN. Mr. Carter?

Mr. CARTER. No questions.

The CHAIRMAN. Mr. Callaway?

Mr. CALLAWAY. No questions.

The CHAIRMAN. Again, we thank you for the very fine statement you have made here today. And we are glad to have your expression of interest in this field.

Governor DEMPSEY. Thank you very much.

The CHAIRMAN. I would like to say that we are also glad to have our colleague Mr. Irwin with us, Governor.

Do you have anything further you would like to contribute, Mr. Irwin?

Mr. IRWIN. No, thank you. There are a lot of people waiting.

The CHAIRMAN. Thank you for your interest. We appreciate your interest in the program. And we are glad to have you come down and join your distinguished Governor.

Mr. IRWIN. Thank you, sir.

The CHAIRMAN. While we are taking the testimony from the Governors and chief executives of the States, I am advised that Mr. Janis, who is the director of the Department of Mental Hygiene and Correction of Ohio, from Columbus, Ohio, is here representing the Governor of Ohio.

Mr. Janis, we will hear you at this time.

STATEMENT OF MARTIN A. JANIS, DIRECTOR OF MENTAL HYGIENE
AND CORRECTION, STATE OF OHIO

Mr. JANIS. Thank you, Mr. Chairman.

Mr. Chairman and committee members, it is a privilege to appear before you to speak in support of H.R. 2985. I am Martin A. Janis, director of the Department of Mental Hygiene and Correction for the State of Ohio.

I am here today representing the Governor of Ohio, James A. Rhodes and the department of State that is charged with providing the care and treatment for the treatment for the mentally ill of Ohio.

As a businessman, I have learned that an expenditure of money can either be an investment or a cost. For this reason to me, this is a vital piece of legislation. In my opinion your approval of this proposed legislation will insure that the investment the Congress has already made in its planning grants to the States and its construction assistance to the communities will bring a fuller return.

As you have gathered, I am not a doctor, nor a psychologist, nor a social worker, but a businessman serving by reason of the decision of the Governor of Ohio that a layman should be the director of this department in the State of Ohio.

The decision whether or not to accept this position was one that I weighed very carefully. The question was, in essence, what could I, as an individual and a businessman, bring to this important task? This department in our State, as I know it is in other States—is the largest and perhaps the most complex in the State. It is also the one department that offers direct service to the people of Ohio—the mentally ill, the mentally retarded, and the inmates of our adult correctional institutions. To be perfectly frank, I accepted the appointment because of the challenge it offered—the challenge of being of service to my fellow man. Through my business enterprises, I have been able to participate in a wide variety of civic activities in my home city of Toledo, Ohio. Serving for many years as president of a number of different civic organizations has been a rewarding experience as was my opportunity to serve as a member of the Ohio Legislature. The directorship of this department offered a new and rewarding opportunity for public service.

In this new position, there were two types of experience that I felt I could bring to bear on the demands of the department. Experience in business and that of working with thousands of persons with varied interests and backgrounds in a variety of civic activities. Although different, in both the application of management principles is a necessity. I felt then, as I do now, that management principles can as well be applied to the operation of a large department of State; yes, even one serving human needs, as to a business or any civic effort. In each you aspire to an objective. In each you are required to obtain maximum benefit from the available dollar. In mental health and mental retardation the dollars are limited and the need is great. Every available dollar must be carefully used—to do otherwise is to deny a measure of help to people who are unable to help themselves.

There is another facet of this problem of mental illness to which I wanted to give my attention. It was a strong personal feeling of the lack of public attention, the lack of understanding by our society of the nature of mental illness. As you very well know in any effort

where you must reach the people whether it is politics, civic affairs, or business, the image you create will be the most important factor in the success you achieve. The image of mental illness has been a poor one—one that has hindered the development of the needed public support of programs to deal with the problems of mental illness. Many, if not most people, still look at mental illness as something incurable, as evidence of lack of willpower, as punishment for some wrongdoing, as something to whisper and to joke about. I have tried, through my position as director of the department of mental hygiene and correction, to deal with this problem of the image—or, if you will, the lack of understanding concerning the mentally ill.

We in Ohio were enthusiastic when the Federal Congress determined to encourage and support long-range and comprehensive mental health planning. Planning is an essential element in any management practice. It should not be any less essential in providing mental health services. In addition, it gave us an opportunity to seek changes in public attitudes about the mentally ill—or if you will, to change the public image of the mentally ill.

By the same token when the Congress enacted Public Law 88-164, a vehicle was provided to usher in a new era of patient care—the era of comprehensive, community services. In our State, as you heard from the Governors who preceded me, we had already begun to develop a community emphasis for mental health services.

The 105th Ohio General Assembly in 1963 enacted legislation making it possible for the State hospital to provide outpatient mental health services as well as the traditional inpatient services. Under this new authority, our hospitals instituted what we refer to as hospital community service units which can and are offering comprehensive psychiatric outpatient services, as well as day care, night care, and other forms of therapy. This has been a fast growing program—one that is focused on keeping the patient in his community and, whenever possible, on his job—as a useful and contributing member of society. Although the hospital community service unit program is just developing, last year alone we were able to treat 13,062 patients. Compare this with the 18,563 patients treated in our inpatient services last year and you can understand our optimism in that we feel that within 3 years we will be treating more patients in our outpatient clinics than in our inpatient programs.

Particularly noteworthy is the fact, that were it not for these hospital community service units, many patients would have required resident admission to our hospitals. Gratifying as the results have been, our concern is that we are not able to provide these comprehensive services to all communities as we are limited to those communities in which our hospitals are located.

The comprehensive mental health planning program has provided the opportunity to enlarge on this concept of patient care. We now look forward to the provision of comprehensive mental health programs under a variety of auspices in Ohio.

Speaking of comprehensive mental health planning, it was a privilege a week or so ago to attend the National Conference on Mental Health under the sponsorship of the American Psychiatric Association held in Washington. There, I learned that about 30,000 persons in the Nation were involved in mental health planning. In Ohio, we are proud of the fact that we have over 3,000. Every one of our

88 counties has a representative group of citizens now completing plans for the development of community-based services for their mentally ill and mentally retarded.

For example, nine applicants have already filed letters of intent for assistance to construct comprehensive mental health centers under Public Law 88-164. These requests have come from private non-profit psychiatric hospitals, universities, general hospitals, and from community mental health clinics.

The total construction cost of this initial nine applicants will be approximately \$8 million. Several of these applicants should be able to make use of the construction assistance available this fiscal year. Others are planning to use only their own resources. In Ohio, the moneys available under title II of Public Law 88-164 will be expended this first year, but will not meet the need that exists for such facilities.

Under title I, part C of Public Law 88-164, 12 letters of intent for the construction of facilities for the retarded have been received. This construction is estimated to be in excess of \$10 million. We will again use all of the funds available under the title, but the need far exceeds the available assistance.

I believe, in some small measure, this suggests the level of interest and acceptance of this approach in Ohio. In many ways the construction assistance has moved closer to reality the dreams of many of our communities to provide badly needed facilities and services for the mentally ill; programs that are truly community oriented, programs that the community has a hand in financing as well as directing.

Our communities are faced with the hard problem of financing the operation of these new and expanded programs. The State of Ohio stands ready to assist them through our support of their community mental health clinics. We have 37 such clinics offering outpatient diagnostic treatment and consultative services. We expect that many of these clinics will be the hub for the development of comprehensive mental health centers. Many will add day-care services and contract with hospitals for their inpatient services. Unlike many States that offer just 50-percent support for these clinics, Ohio supports them with up to two-thirds of their operating costs. Nevertheless, the addition of new services together with other expenses for an expanded operation will pose some very difficult problems to our communities in securing the necessary additional financing in the early years of their operation.

In many communities it will be impossible to think of comprehensive services without some additional assistance.

May I bring to your attention our experience in Ohio in using Federal assistance in developing community mental health programs. It has been indicated that once operational money has been provided it will continue without either the community or the State assuming an increased portion of the total cost. Originally in Ohio, the Federal Government assumed the total cost of the development of the community mental health clinic program. From 1948 through 1950 the Federal funds provided 100-percent support in amounts ranging from \$35,943 one year to \$115,702 the last year. As the clinic program progressed to its present number of 37, State and local fund participation increased and the Federal contribution decreased. In fiscal year 1964, the total expenditure of our community mental health clinic program was \$2,743,818 with Federal participation totaling \$189,992 or approximately 7 percent. From full participation of 100 percent

to approximately 7 percent of an ever-increasing program proves the wisdom of Congress in providing this "seed" money for the development of this program in the Mental Health Act of 1946.

I firmly believe that Federal assistance in meeting the initial cost of operations is a must—a must if we are going to capitalize on the momentum that has been developed.

Such support would give our community and financial leaders a breathing spell—a period of time—in which they can adapt their traditional public and private funding patterns to the needs of our fast-changing, automated communities. As you gentlemen know, traditions of governmental responsibilities, administration, and financing die hard and are slow to change, at any level of government. But they do change when it becomes apparent that such a change is necessary to meet a public demand. The proposal before you would make possible the gradual, sound, and long-range development of our mental health preventive and treatment program, without requiring indefinite Federal commitment to the support of the program.

Yes, gentlemen, your approval of this bill will provide that necessary incentive communities must have if we are to fully realize the benefits so desperately needed. I know that many of my colleagues in business and labor feel as I do. Last Friday, when I learned that I would have the opportunity of speaking as a proponent of this bill, I asked a member of my staff to check with some of our business and labor officials around the State as to their position on this bill. By Monday, I had a desk piled high with letters endorsing the need for this investment of Federal funds. I have brought a few that I would like to submit with this prepared statement.

(The letters referred to are as follows:)

CLEVELAND, OHIO, *March 3, 1965.*

MARTIN A. JANIS,
Care of Hay-Adams Hotel, Washington, D.C.

Re your testimony for H. R. 2985, may I respectfully urge favorable committee action. Federal assistance in the enormously worthwhile project of community centers is of crucial importance to Ohio and our community.

LARRY ROBINSON,
President, J. B. Robinson Co., Jewelers, Inc.

THE TAIT MANUFACTURING Co.,
Dayton, Ohio, March 1, 1965.

Mr. MARTIN A. JANIS,
*Director, Department of Mental Hygiene and Correction,
Ohio Department Building, Columbus, Ohio.*

DEAR Mr. JANIS: In our work on the mental health planning project we have found that the most urgent need in our locality is for staffing of facilities. Bricks and mortar are useless without the proper staff to implement program.

Federal assistance for buildings and facilities is fine; but such help does not meet our total needs. The fundamental requirement is for some type of assistance to enable us to staff the facilities once they are built.

All best wishes for success in your efforts.

Sincerely,

LOUIS WOZAR,
President and General Manager.

ZANESVILLE, OHIO, March 1, 1965.

MARTIN JANIS,
*Director, Ohio Department of Mental Hygiene,
State Office Building,
Columbus, Ohio.*

DEAR MARTIN: When I heard you are to testify before a House congressional committee regarding H.R. 2985 which provides operating moneys for comprehensive mental health centers I decided to wire and convey my thoughts on this matter as president of the board of directors for the Muskingum Valley Guidance Center. Locally, we have raised matching funds for construction of a comprehensive mental health center in Zanesville. This is a great step forward, but in order to be absolutely effective adequate operating funds must be available. This is a problem today. I wish to go on record favoring Federal assistance for operating funds.

Very truly yours,

PAUL E. QUINN,
President, Muskingum Valley Guidance Center.

KENT, OHIO, March 1, 1965.

MARTIN A. JANIS,
*Director, Department of Mental Hygiene & Correction,
State Office Building,
Columbus, Ohio:*

I strongly support pending legislation to provide Federal support for local mental health services. The long-range social and economic value of such aid cannot be exaggerated.

PAUL PORTEUS,
President, Kent Area Chamber of Commerce.

TOLEDO, OHIO, February 27, 1965.

HON. MARTIN A. JANIS,
*Director, Ohio Department of Mental Hygiene & Correction,
State Office Building, Columbus, Ohio.*

DEAR MR. JANIS: It has come to my attention that you are to testify before the congressional committee that is considering legislation to amend Public Law 88-164 so as to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers.

As one who for many years has engaged in various voluntary activities in local Toledo mental health programs, I would like to go on record favoring the above legislation.

With the rapidly changing concepts in the prevention and treatment of mental illness, with the emphasis toward community based services, our local communities have been challenged with far greater responsibility than ever before.

Public Law 88-164 provides matching construction funds for comprehensive community mental health centers but unfortunately most communities are not in a position to assume total financial responsibility for their operating costs.

I strongly support the principle of multiple forms of financing, and believe that every effort must be made to secure not only more voluntarily contributed funds, increased use of personal resources, and greater insurance coverage, but also increased public funds from all levels of government. Facilities alone do not insure service.

I also support continued Federal assistance for ongoing coordination and planning for mental health services at both State and local levels. Every effort must be made to avoid the high cost of overlapping and duplication of effort.

Sincerely,

RUTH IDE
Mrs. Charles Ide., Jr.

THE AMERICAN LIGHT CO., INC.,
Zanesville, Ohio, February 27, 1965.

Mr. MARTIN JANIS,
Director, Department of Mental Hygiene,
State Office Building, Columbus, Ohio.

DEAR SIR: It is my understanding that you are to testify before a committee of the U.S. House of Representatives concerning proposed H.R. 2985, which provides operating funds for community comprehensive mental health centers.

With the passage of Public Law 88-164 which has already provided for Federal participation in the erection of these centers, provisions for operating them would be the next logical step. Nothing could be more unfortunate than buildings without adequate staff to give full community service.

We in Muskingum County have already voted the funds necessary for a center, and are now in the process of applying for Federal participation under Public Law 88-164. We hope we will be able to staff the center. Passage of H.R. 2928 would be a most beneficial move in that direction.

Sincerely,

BERNARD GOLDSTEIN,

Member of Committee for Comprehensive Mental Health Planning.

SPRINGFIELD, OHIO, March 1, 1965.

Mr. MARTIN A. JANIS,
Director, Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.

DEAR MR. JANIS: This letter should reach you before your departure for Washington.

We certainly wish you every success in your efforts to secure Federal funds for the hiring of staff for mental health facilities throughout the Nation.

As president of the guidance center, mental health facility serving Springfield, Clark County, and other nearby counties, I desire to stress the desperate need for more staff for our clinic.

We should have two psychiatric social workers and have not had one in the 10 years during which I have been affiliated with the center.

We recently lost our psychiatrist because he found a position with the Veterans' Administration at higher pay.

Our need is desperate, and no doubt other clinics throughout the State are fully as desperate.

Respectfully yours,

J. P. WILSON, *Attorney at Law.*

MOUNT VERNON BROADCASTING Co.,
Mount Vernon, Ohio, February 27, 1965.

Mr. MARTIN A. JANIS,
Director, Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.

DEAR MR. JANIS: We understand you will be testifying before the House congressional committee regarding operating funds for community mental health centers.

We feel Federal assistance is absolutely necessary for operating moneys in order to make the planned program possible in our area. Would you please convey our attitude on this matter.

Sincerely yours,

HELEN E. ZELKOWITZ,
Mrs. Charles M. Zelkowitz, *President.*

MUSKINGUM COUNTY PROBATE COURT,
Zanesville, Ohio, February 27, 1965.

Mr. MARTIN JANIS,
Director, Ohio Department of Mental Hygiene,
State Office Building, Columbus, Ohio.

DEAR MARTIN: It is my understanding that you are to testify before a House congressional committee regarding H.R. 2985 which provides operating money for comprehensive mental health centers.

I want to convey my thoughts on this matter as regional chairman of the Citizens' Committee for Comprehensive Mental Health Planning. Public Law 88-164, which provides construction money for comprehensive centers, provides an excellent basis for building such centers. However, we do not want to see these structures stand empty due to a lack of mental health manpower. In view of the fact that there is a shortage of State and local money for such operating funds, I should like to go on record as urging the need for Federal assistance in the initial operation of these centers.

As you know, we have already raised funds for the community share of construction money for a comprehensive center in Zanesville, and provisions of operating funds will assure the success of our center.

Very truly yours,

HOLLAND M. GARY,
*Probate Judge,
Chairman, Region IV,
Comprehensive Mental Health Survey.*

OHIO AFL-CIO,
Columbus, Ohio, March 3, 1965.

MARTIN JANIS,
*Director, Department of Mental Health and Correction,
Columbus, Ohio*

DEAR MR. JANIS: It has come to our attention that you will be testifying before the House Interstate Commerce Committee on H.R. 2985. We would like to take this opportunity to prevail upon you to pass along to the committee hearing on the bill the views of our organization on this important piece of legislation.

Labor in Ohio supported the late President Kennedy's mental health program and has actively engaged in the comprehensive mental health planning required by that program. The planning efforts today have highlighted the need for immediate action in this area of great social concern. However, we in labor know full well that the "bricks and mortar" provided by the present Federal program will not accomplish the job. Operational and staffing costs must also be met.

Although under the present Federal program, most of the planning will have been done and some moneys will be available for facilities, many of our local communities will be discouraged from ever entering the comprehensive mental health program because of a lack of local funds. To be frank, not only local coffers but also local taxing sources in many communities are completely exhausted. If we expect to have high-quality community mental health centers, available to all, help is certainly going to be needed on the local level with the operational expenses of these institutions. Therefore, our organization is definitely in support of H.R. 2985.

We wish you would pass the above views on to the Interstate Commerce Committee and urge the committee to vote favorable on H.R. 2985.

Sincerely,

ROBERT D. BOLLARD, *Secretary-Treasurer.*

WILLIS DAY STORAGE Co.,
Toledo, Ohio, March 1, 1965.

HON. MARTIN A. JANIS,
*Director, Ohio Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio*

DEAR MR. JANIS: It has come to my attention that you are to testify before the congressional committee that is considering legislation to amend Public Law 88-164 so as to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers.

As a lay citizen who for many years has engaged in varied voluntary activities in local Toledo mental health programs, I would like to go on record favoring the above legislation.

With the rapidly changing concepts in the prevention and treatment of mental illness, with the emphasis toward community-based services, our local communities have been challenged with far greater responsibility than ever before. Public Law

88-164 provides matching construction funds for comprehensive community mental health centers, but unfortunately most communities are not in a position to assume total financial responsibility for their operating costs.

I strongly support the principle of multiple forms of financing, and believe that every effort must be made not only to secure more voluntarily contributed funds, increased use of personal resources, and greater insurance coverage, but also increased public funds from all levels of government. Facilities alone do not insure service.

I also support continued Federal assistance for on-going coordination and planning for mental health services at both State and local levels. Every effort must be made to avoid the high cost of overlapping and duplication of efforts.

Yours truly,

THOMAS R. DAY.

MARTIN CHEVROLET, INC.,
Warren, Ohio, March 1, 1965.

Mr. MARTIN JANIS,
State Office Building, Columbus, Ohio.

DEAR MR. JANIS: I want to add my voice to that of other interested citizens to urge the support of the mental health effort in Ohio by the Federal Government.

The need is great and as an industrial State we certainly stand in need of this support.

The problems of today may seem insignificant under tomorrow's population explosion.

The time to act is now.

Sincerely yours,

PAUL E. MARTIN.

THE OHIO CITIZENS TRUST CO.,
Toledo, Ohio, March 1, 1965.

Mr. MARTIN A. JANIS,
Director, Ohio Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.

DEAR MARTIN: I have been a member of the board of the Toledo Mental Hygiene Clinic for a number of years, and currently am chairman of the steering committee of the Lucas County Community Health Study which, among other areas, includes mental health.

Also, as you know, I spent many years on the budget committee of the Toledo Community Chest and am quite familiar with the difficult problem of financing adequate health services. For that reason, I am particularly interested in the amendment of Public Law 88-164 to authorize matching funds for the staffing and/or operational cost for local community mental health centers.

Sincerely yours,

Bob,
ROBERT L. KNIGHT,
Executive Vice President.

THE UNION NATIONAL BANK,
Youngstown, Ohio, March 1, 1965.

Mr. MARTIN JANIS,
Director, Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.

DEAR MR. JANIS: I understand that you are planning to testify in behalf of the revision of Federal legislation which would provide Federal funds for the staffing and operation of community mental health services.

I have been personally concerned with the mental health movement for a number of years, and have been involved in the development of mental health services in the Youngstown area. One of the critical issues facing communities is the lack of funds and manpower to properly carry out mental health programs. This is specially frustrating in view of the advanced knowledge we have today which would allow us to carry out programs, were the finances available.

The cost to business and industry, due to emotional problems of the work force, is so severe that every business is aware of the growing problem.

As president of the Mahoning County Health Association, and in behalf of the many business and community leaders in our membership, I would like to wholeheartedly endorse your efforts in behalf of the mentally ill and mentally retarded.

Sincerely,

E. W. BRAUNINGER,
Vice President.

THE DAYTON POWER & LIGHT CO.,
Dayton, Ohio, March 1, 1965.

MR. MARTIN JANIS,
*Director, Department of Mental Hygiene and Correction
Ohio Departments Building, Columbus, Ohio.*

DEAR MR. JANIS: I have been informed that you are to testify on Thursday, March 4, on behalf of Federal assistance for staffing of our comprehensive mental health centers.

As a member of region 7 mental health survey committee I have become acutely aware of adequate staffing of all our mental institutions as our greatest need. This problem is with us now even with our present limited and very inadequate program. With the enlarged program, as visualized through comprehensive mental health centers, adequate staffing would be next to impossible without Federal assistance.

In my opinion, the lack of Federal assistance for staffing of mental institutions has been the principal deterrent in interesting young people to enter this essential field of learning. In view of the limited resources of the various States the future of this particular and very specialized profession has not been bright. Some reasonable Federal assistance would not only provide a means whereby important and long overdue salary adjustments could be made but, what may be more important, indicates a national awareness of the importance of this field of medicine to the general welfare of the Nation.

Please accept my very best wishes for every success in this very important effort.

Sincerely,

E. D. SMITH,
Vice President, Public and Industrial Relations.

TEMPLE BETH EL,
Steubenville, Ohio, February 28, 1965.

MR. MARTIN JANIS,
*Director, Department of Mental Health,
State Office Building, Columbus, Ohio.*

DEAR MR. JANIS: As you know, I have been most active in the mental health activities and programs in Jefferson County and in the city of Steubenville. It is in this capacity that I write to you.

I urge you to use your good offices to inform Federal authorities that Public Law 88-164 which provides only physical facilities for the treatment of mental illness is totally inadequate to meet the real needs of our community. Facilities are no substitute for trained and skilled staff. And until such time that we are able to find the necessary staff to perform the functions of our clinics, hospitals, and institutions the physical facilities are of little value. It is the staff and not the facilities that serve the needs of the mentally ill.

My experience in our own community has convinced me that Federal aid will be necessary for staff services as well as facilities if Public Law 88-164 is to be of any concrete assistance to us.

I urge you to impress upon the Federal Government that it must consider the tremendous need of professional services in its present and future plans to cope with the mental health dilemma that faces our Nation. Do inform me as to how I may assist you and your department in your efforts to meet the needs of our State in providing more effective and comprehensive services and facilities for those of our citizens suffering from emotional and mental illness.

Yours truly,

RICHARD B. SAFRAN, *Rabbi.*

PRESCOTT & Co.
 Youngstown, Ohio, February 26, 1965.

MR. MARTIN A. JANIS,
 Director, Department of Mental Hygiene and Correction,
 State Office Building, Columbus, Ohio

DEAR MR. JANIS: It is my understanding you will testify before the legislature as to the proposal under Public Law 88-164 for the staffing of the comprehensive mental health centers.

I cannot emphasize strongly enough my personal feeling as to the need for legislation which will insure the competent staffing of such proposed centers. As one who has been intimately involved in the mental health field for many years I have well understood the personnel problem confronting mental health institutions. Unless steps are taken to correct this dilemma before such centers become a reality, we are, in my opinion, inviting disaster. Specific action must be taken.

I would, therefore, implore you to speak in behalf of this critical legislation. Then, under Public Law 88-164, we can insure adequate staffing for such centers.

Cordially yours,

ROBERT E. BULKLEY,
 General Partner.

THE FIRST BAPTIST CHURCH,
 Youngstown, Ohio, February 26, 1965.

MR. MARTIN A. JANIS,
 Director, Division of Mental Hygiene and Correction,
 State Office Building, Columbus, Ohio.

DEAR MR. JANIS: You do not know me, so let me first introduce myself, briefly. I am serving presently as the county chairman, for Mahoning County, of the comprehensive mental health study now going on, as well as the president of the Adult and Child Mental Health Center, Inc., which is the corporate body presently working on raising the funds and working out the details for a comprehensive mental health center here.

In the many hours which we have spent on studying our own community's needs, the years of work done by existing agencies to develop much more help both in the treatment and prevention of mental and emotional disorders, we have come to realize some facts. Among the most important facts which we must face, is the great, great need for adequate staff and operating funds for the tasks which we are called upon to meet. In my humble opinion, no local community, certainly at this point, can come anywhere near raising enough moneys to do the job. While the great work of the United Funds do produce a base amount, and while State and/or Federal help adds to this, we already know that an adequate job can only be done when more funds for the operation of such complete mental health centers as we are working on hard here can be made available.

It is my understanding that the Congress of the United States is seriously considering a bill or bills which would assist in this area of need. As one citizen that has, through the years, given considerable time to this problem, I cannot urge strongly enough the need for such help. In my own profession I see people constantly who need such help. But our communities cannot provide what is needed. We are running behind faster than we can run ahead.

With the complex culture that we have, with more and more persons in our separate communities finding themselves unable to cope with this, we simply need more staffs and more help than we can provide. The mental health of the Nation is of singular importance. If we as a people cannot keep integrated as persons, if we find we must hospitalize more and more people simply because we do not make available services and skills early enough to be of help, we not only increase tremendously the tax burdens for existing institutions, we lose productive citizens, further depress economic factors, and add to the numbers of families that must receive yet other forms of assistance, such as welfare or children's services.

May I add my urgent request that the Congress consider favorable and act in the affirmative on proposals now before it to make Federal moneys available in some way for the tremendous needs of operating adequate mental health facilities in the various communities across America.

Most sincerely,

ROGER H. SHARPE, Minister.

OHIO SENATE,
Columbus, February 27, 1965.

Mr. MARTIN A. JANIS,
*Director of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.*

DEAR MR. JANIS: It is my understanding that you are appearing before a House congressional committee regarding operating moneys for comprehensive community mental health centers.

I have been engaged in a regional planning project and know that there is a need for operating moneys for these centers. Further, we do not wait to see these buildings constructed, only to stand empty for a lack of professional and trained personnel.

Therefore, I urge that Federal assistance be granted for the initial operation of such centers.

Sincerely,

EDMUND A. SARGUS.

THE BAILEY DRUG CO.,
Zanesville, Ohio, February 27, 1965.

Mr. MARTIN JANIS,
*Director, Ohio Department of Mental Hygiene,
State Office Building, Columbus, Ohio.*

DEAR MR. JANIS: It has come to my attention that you will be testifying in the near future before the congressional committee in Washington, in regard to the bill which proposes to provide Federal operating funds for community mental health centers. As a member of the board of the Muskingum Valley Guidance Center and a past president of this board, I have a great interest in the application which is being made for a comprehensive mental health center in Zanesville. While we have raised our share of the construction funds by a tax levy and we are confident that our center can be completed, it would be of great assistance to us and to other communities similarly situated if some funds for operation of the center, particularly in the initial years of operation, could be provided from Federal funds. I trust that you will convey to the committee our extreme interest and concern in southeastern Ohio, and will be able to persuade them to recommend House bill 2985 for passage.

Very truly yours,

WILLIS B. BAILEY, *President.*

LAW OFFICES OF POMERENE, BURNS, MILLIGAN & FRASE,
Coshocton, Ohio, February 27, 1965.

Mr. MARTIN A. JANIS,
*Director, Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.*

MY DEAR MR. JANIS: I understand that you are to testify before a House congressional committee regarding funds for the operation of comprehensive community mental health centers.

The need for such community centers has repeatedly been brought to my attention in my more than 40 years of work as a country lawyer. I sincerely believe that Federal funds are necessary in order to provide such centers and therefore strongly urge you to request Federal assistance for funds to staff community health centers and especially to provide adequate salaries for highly trained personnel so that the work of such community centers can be fully effective.

Respectfully,

W. M. POMERENE.

U.S. AUTOMATIC CORP.,
Amherst, Ohio, February 26, 1965.

Hon. MARTIN A. JANIS,
*Director, Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.*

DEAR MR. JANIS: I understand that you are going to appear before the House committee in behalf of the Federal legislation contained in H.R. 2985 which will provide for operating funds for community mental health centers. For many

years I have been vitally concerned with the mental health services in our State and have taken an active part in local and State mental health programs.

At the present time I am serving as president of the Ohio Mental Health Association, also chairman of the board of the Lorain County Guidance Center and the local mental health association. In these capacities I have been very much aware of the acute need for expansion of our community mental health programs to take care of persons in need of early diagnosis and treatment. One of the greatest stumbling blocks has been the lack of sufficient funds for personnel to implement these facilities.

I am currently serving as a member of the Comprehensive Mental Health Planning Survey Committee which is preparing a blueprint for service to be developed in Ohio. It would be impossible for our State to carry out this program without Federal funds provided for the operation of these services. In your testimony before the congressional committee I shall be pleased to have you add my support for the approval of this legislation, both in my capacity as the president of the State organization and also as an interested citizen of Ohio.

Very truly yours,

WALTER G. NORD, *President.*

TOLEDO, OHIO, March 1, 1965.

HON. MARTIN A. JANIS,
*Director, Ohio Department of Mental Hygiene and Correction,
State Office Building,
Columbus, Ohio.*

DEAR MR. JANIS: It is my understanding that a congressional committee is soon to meet to consider legislation authorizing operating funds for Public Law 88-164, and that you may be called upon to testify before this committee.

If community mental health centers are to be a success, Federal assistance with operating funds is essential right at the beginning of the program. Otherwise, there will be endless delays while communities struggle to find ways and means to shoulder the initial large cost of these mental health centers. However, once the program is underway and the public sees the vast benefits it is receiving from these centers, I am confident it will be ready and willing to assume its responsibilities in meeting the expense of technical and professional personnel.

While I have been involved in local mental health work for years as a layman, it has been most interesting to observe the fast growth in public interest in mental health problems. And this is why I believe the public will be prepared to carry on once a mental health center is quickly and effectively established with the aid of Federal funds.

Sincerely yours,

GEOFFREY R. BENNETT.

MENTAL HEALTH FEDERATION, INC.,
Cincinnati, Ohio, March 2, 1965.

HON. MARTIN A. JANIS,
*Director, Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.*

DEAR MR. JANIS: We are very much pleased that you have been invited to testify before the committee of the House of Representatives of the Congress with respect to H. R. 2985 relative to funds for initial staffing of community mental health centers. As you well know, adequate professional and supporting staff is essential for the operation of mental hygiene facilities and obtaining such staff for the new comprehensive community mental health centers will be of critical importance. The stimulation of the Federal Government in providing for the planning for such centers and in providing initial construction funds to be matched at other levels has proved the value of these programs. We are convinced that such stimulation is necessary in order to attract and keep the professional and semiprofessional personnel required for operating the centers.

Mental Health Federation, Inc., both directly and through its 23 local affiliated associations throughout Ohio, has supported the comprehensive planning program and through its members and trustees has participated in the planning process. We see the planning effort and the resulting community centers together with other facilities being developed through the efforts of your department and many local community agencies as the most hopeful indication of progress in combating mental illness in our generation. We cannot afford to let these efforts fail or to

lose the support of the more than 3,000 citizens of Ohio who have participated, in one way or another, in the planning effort because we are not in a position to attract personnel.

Accordingly, we urge your support of H.R. 2985 and stand ready to assist you in any manner we can in achieving passage of this most important legislation.

Sincerely,

JAMES E. CHAPMAN, *President.*

THE CLEVELAND MENTAL HEALTH ASSOCIATION,
Cleveland, Ohio, March 2, 1965.

MARTIN A. JANIS,
*Director, Department of Mental Hygiene and Correction,
State Office Building, Columbus, Ohio.*

DEAR MR. JANIS: We are informed that you will be testifying concerning H.R. 2985, which is designed to provide initial operating expenses for staffing community mental health centers on a predetermined pattern of diminishing Federal participation leading to ultimate withdrawal of Federal support.

The Cleveland Mental Health Association approves and heartily supports this legislation and urges its enactment. As an organization, and individually, we are apprising our Senators and Congressmen of our support for H.R. 2985.

We believe this Federal financial aid to the States is vital to the enlightened action Congress has initiated in the development of a Federal comprehensive mental health program.

Sincerely yours,

CHARLES W. LANDEFELD,
President.

PORTSMOUTH AREA CHAMBER OF COMMERCE,
Portsmouth, Ohio, March 2, 1965.

Mr. MARTIN A. JANIS,
*Director, Department of Mental Hygiene and Correction,
Ohio Departments Building, Columbus, Ohio.*

DEAR MR. JANIS: It has come to our attention that you are to appear before the U.S. congressional committee considering House bill No. 2985.

The chamber of commerce has long been aware of the necessity of extending our mental health facilities. We sincerely urge that you advocate congressional appropriation, facilitating construction of community mental health centers.

If we can assist you in presenting the needs of the Portsmouth area, please let us know.

Very sincerely,

BILL N. PURDY,
President.

PORTSMOUTH PUBLIC SCHOOLS,
Portsmouth, Ohio, March 2, 1965.

Mr. MARTIN A. JANIS
*Director of Mental Hygiene and Correction,
Ohio Department Building, Columbus, Ohio.*

DEAR MR. JANIS: In your appearance before the House congressional committee, I would like to request, as superintendent of the Portsmouth city schools, that you give full support to H.R. 2985.

I understand that Public Law 88-164 provides assistance for construction funds only. If this is true, then the areas of Appalachia may find great difficulty in staffing problems due to inadequate finance which could severely hamper any progress needed in our community health program.

I believe that I speak for many people within our system who are aware of the many mental health problems in our schools of today.

Thank you very much, Mr. Janis.

Sincerely,

C. HAROLD DUDUIT, *Supervisor.*

THE WILLIAMS MANUFACTURING CO.,
Portsmouth, Ohio, March 2, 1965.

Mr. MARTIN A. JANIS,
Director of Mental Hygiene and Correction,
Columbus, Ohio.

DEAR Mr. JANIS: I just learned that you are scheduled to testify in Washington, D.C., in a couple of days regarding House bill No. 2985 relative to the mental health program.

As supervisor of our employee health program which covers approximately 2,200 employees and their dependents (an additional 4,500), I am vitally interested in the mental health program and funds available through President Johnson's war on poverty.

We understand that Public Law 88-164 will provide money for construction of mental health centers but will not provide funds for the staffing of these centers. We in the shoe industry cannot make shoes with just buildings and machinery. We must have properly trained personnel to operate these machines and equipment. Likewise, we will need trained personnel to operate the community health centers.

Scioto County is one of the 28 counties in Ohio which has been designated as part of the Appalachia program and I feel that I speak for all of our employees and their families relative to the need for health facilities in our community.

We need more money to hire trained social workers, psychologists, psychiatrists, teachers for classes for emotionally disturbed students and particularly professional people for help with our retarded children in this area.

We urge you to convey this message to the House congressional committee so they may recommend appropriations for the staffing of these mental health centers.

Rest assured that we appreciate your continued interest and cooperation in our community.

Yours truly,

T. H. NICHOLS, *Health Program Director.*

Mr. JANIS. Incidentally, and particularly because Congressman Farnsley asked the question, I am sure that in expressing his feeling about what the thinking might be in the community concerning this movement, and what might be described as another advance into socialization, that certainly businessmen and labor leaders would be the first to express particular feeling in that regard. As I have said, every letter that I have received has been in support of this opportunity of mine to appear concerning the staffing bill.

Another example of the consensus of the need for Federal assistance in meeting the initial operating cost of comprehensive mental health centers is the action taken by our Citizens' Committee on Comprehensive Mental Health Planning. On March 22, 1965, the citizens' committee will submit an interim report to the Governor of Ohio. In this report they recommend that Federal funds should be made available to assist communities in the operation of comprehensive centers serving the mentally ill and mentally retarded. They, too, feel as the Governor of Connecticut said, that if the job is to be done, the community, the State, and the Federal Government must join hands in behalf of improved programs for the mentally ill. May I note again that we have over 3,000 citizens involved in our planning study. Part of this was because we felt that the greater the involvement the better our opportunity in reaching the people so that they can understand the need for support in this area.

I could cite you additional statistics on the dimensions of the mental health problem as it is being measured in Ohio. There will be many cited to you in the course of your hearings by people better qualified than I. There is just one measure that I would like to bring to your attention, it results from the comprehensive mental health study in one of our regions in Ohio. As it happens, the one, in which is located a distinct represented so ably on this committee by the

Congressman from Cincinnati. This special study was on the origin of patients being served by different types of mental health facilities. The study which was conducted in Cincinnati, Ohio, showed that patients from the poor areas of Cincinnati used our State hospitals up to 14 times as frequently as patients from more prosperous areas of that city. In my opinion, this highlights our problem. Our greatest unsolved mental health problem remains with the poor—the aged. * * *

Gentlemen, I have heard references all morning to this matter of custodial care. Primarily this would relate to the aged who were in our hospitals because there was no other place for them.

In my beginning days it was a shock to learn that many of those within our resident population had been there for so many years, had become institutionalized and were not there at all to receive mental treatment. And I am sure that this is a tragedy about which something must be done, the matter of the treatment or the development of programs for our aged with limited incomes, who should not be in our mental hospitals. Then, of course, as the Governors brought out so well, there is the growing problem of the young. These are the people—the poor—the aged—and the very young—who can't afford to purchase their own mental health care. The proposed centers offer a hope for the future. The services to these people will have to be at public expense and they should be, for our society has the need of every one of its citizens. This again illustrates the investment quality of this bill—an investment in human values.

In conclusion, Mr. Chairman, I should like to thank you and the members of the committee for allowing me to present my views on the proposal before you, which are fully supported by Governor Rhodes. I feel that we can turn the flow of mental health services dollars to better us if, through the passage of this bill, we are given the necessary aid that will permit immediate, not future, development of the community comprehensive mental health center. At the same time, and I am happy that I made a note of this by reason of the question that Congressman Gilligan from my State posed to Governor Kerner, I think—I had stated then, and I state now, I pledge to you that in our State—and I know this would be true in all of the others—as in the instance of Federal “seed” money provided for community mental health clinics which I cited to you previously, Federal support need not continue indefinitely, but only for the period as provided in this bill so that we will have the necessary time to assemble the resources that we will need.

The CHAIRMAN. Thank you very much, Mr. Janis, for your very concise, explicit, and to the point statement. You have just about answered all the questions I have.

But in view of the fact that we have just discovered that there are poor centers in Cincinnati, I will ask Mr. Gilligan if he has any question.

Mr. GILLIGAN. Thank you, Mr. Chairman.

Mr. Janis, I admit to some confusion in the field of the discussion of some of these institutions. How many State hospitals and institutions do we have in Ohio for the care of the mentally ill?

Mr. JANIS. We have 20. Eleven of them are what one would call the prolonged care hospitals with which we are mostly familiar, and about which we hear so much, which have been in the public eye and

which represent, to a great degree, the human warehouses. They have the majority of our resident population between 20,500 and 21,000.

And then, we have six receiving or intensive treatment hospitals, which include hospitals that also have residency programs for the training of psychiatrists. And we have three children's psychiatric units. So there are the 20; 9 intensive treatment and 11 prolonged care. As it was pointed out this morning there is an overlapping of services in the prolonged care hospitals for as the public becomes more conscious of the image of mental health, and insists on something being done, other services have been added to these individual institutions so that some of them offer intensive treatment programs too.

Mr. GILLIGAN. What did you say was the total population of those facilities?

Mr. JANIS. 22,000. You might be interested in knowing—I am sure that it was brought to your attention, because it was a release, I presume, by NIMH, pointing to the decrease that has occurred in the resident population in the last decade, that our figures in Ohio are a little bit better than the national figures. We have dropped from approximately 30,000 in 10 years to the 22,000 that I have mentioned. And for the first time in November, we dropped below 22,000; the first time we have been under 22,000 in quite a number of years.

Mr. GILLIGAN. I am a little confused. On page 4 of the statement you just read to us, you refer to 18,463 patients treated in our in-patient services last year?

Mr. JANIS. Yes; that is the number discharged as successfully treated who had been inpatients and went back into the community. That is the reference that is made there.

Mr. GILLIGAN. Is that to be added to the 22,000, or is it a portion of the 22,000?

Mr. JANIS. In determining the total number that would be treated, you would add that number to the number that you have as of the end of the date, whatever that might be, and that would give you the total number that went through the hospital during the year. I was only referring, Congressman, to the number who had been treated during the year; in other words, successfully treated by being returned to the community.

Mr. GILLIGAN. I believe that in 1960, at the turn of the decade, the patient population of our mental hospitals in Ohio was considered to be 33,500. Is that figure correct?

Mr. JANIS. Congressman, you have included in the number those that are in the mentally retarded institutions also. You see, 20 is the total number of hospitals for the mentally ill. We have 5 that are for the mentally retarded, and they have a population of approximately 10,000, so that in total it would be about 33,000.

Mr. GILLIGAN. That is what I was trying to get straightened out, because I could not compare those figures of a few years ago with now. But if you add in the mentally retarded population, you say, it brings it up to a figure about 33,000.

You refer, Mr. Janis, to certain new programs that are underway in Ohio in community mental health programs, and so forth; and of their rapid development. Can you suggest to us in terms of dollars the extent of this development in the last few years; how

much of your budget is being diverted into this kind of community service as compared to the custodial care that was given traditionally?

Mr. JANIS. Yes; I would be very happy to, Congressman, because it happens that this really is my own program—one that I personally directed through our legislature. I had learned that our doctors had indicated that they felt that they could do a much better job if they were able to discharge patients earlier and then be able to treat them on an outpatient basis. Our laws did not permit that. So the reference I made in 1963 was when we were able to get our laws amended to provide this.

By so doing then—and as you can appreciate, 1963 isn't a very long time ago—I was able to allocate approximately \$290,000 that was used for that purpose. Of course, it took time to physically separate the unit, and also to separate the staff. The following year—this would have been the fiscal year 1965, which is the current one, we will spend approximately \$900,000 in this program. And I have in the budget, which is being reviewed by the legislature at the present time, approximately \$2 million for each of the next 2 years.

Mr. GILLIGAN. Now, during that period of time—as you suggest, this is a rapidly developing program, obviously—what was happening to the patient population of your institution, the custodial institutions, the mental retarded institutions, and so forth?

Mr. JANIS. As I mentioned to you, our decline in population is in accordance with the national pattern. So as a result it has been decreasing. One has to be careful in the evaluation of those figures because, naturally as your population might decline, it is not only because of successful treatment but also placement of the aged in nursing homes.

Mr. GILLIGAN. Can you give it as to percentages over a period?

Mr. JANIS. From 2 to 4 percent; the 2 percent approximately is what our decline is.

Mr. GILLIGAN. I believe your total budget during these years in the field of mental hygiene and mental health remained static up to the proposals that presently rest before the general assembly; in other words, just under \$68 million. And your patient load has decreased 2 to 4 percent, but up to a million dollars has been diverted into these community health programs. Would this suggest to you that less money is being expended on the care of your patient population in the conventional State hospital?

Mr. JANIS. No. I had been forewarned, Congressman, that you had asked that question with reference to your State in the first day of the testimony. And may I say to you that for the biennium to be ended June 30, 1965, the amount of money to be spent will be the greatest amount ever spent by the division. It will be about 4 percent more than the preceding biennium. And for this biennium the Governor recommended better than 10 percent more than what will be spent in the last one.

Again, I certainly feel that we undoubtedly could spend more. But we have some other adjustments that we must make first. It is not just a matter of money, Congressman, in itself, it is a matter of utilization of that which we have and the development of those tools that will permit us to spend it in such a manner that is of benefit.

Mr. GILLIGAN. I want to say to the other members of the committee and to Mr. Janis that I am sorry I am taking so much of his time and yours. I would like to further commend Mr. Janis on the statement

made on behalf of the Governor of Ohio and the Department of Mental Hygiene and Correction of the State of Ohio in support of the provisions of H.R. 2985, which I think is a useful statement, and one which will bear great weight with this committee.

Again, my apologies for taking up so much of the time of the committee. I have no further questions.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. I have one.

Mr. Janis, you were here this morning when I interrogated the Governors in regard to the distribution of funds.

Mr. JANIS. Yes.

Mr. YOUNGER. Is your Governor substantially in accord with what the other Governors responded to those questions?

Mr. JANIS. Yes.

Mr. YOUNGER. That is all.

The CHAIRMAN. And are you satisfied that there will be no further request after 4¼ years as provided here by the Congress to provide this statute beyond that period of time?

Mr. JANIS. Yes. As you know from the statement I made, I most certainly pledge that with respect to our own effort in this direction. And I recognize that it is not up to me to rebut statements made by others, but there was the reference that was made by those from the AMA with reference to the fact that—well, I quote here:

Nor is it likely to phase out, and if the community cannot or will not support the program in its beginning years, it is not likely to do so later.

May I say that by reason of the impetus that Congress gave to planning, an assurance has been given that such will continue as was testified, I think by Governor Kerner, as they are going to continue, so are we. And he indicated that other States are, too. By the same token, as I made reference to the community clinic program, the individual communities in our State have measured up to the original intent of the Congress by adding more and more money so that the program has expanded without requesting increased moneys from the Congress. Now they have the means by which to become the hub of a community mental health center. For that reason I feel definitely that given the incentive of the staffing they will fulfill their part.

The CHAIRMAN. I just wanted to make it clear and join others in this record in emphasizing the fact that if this is done, the States are on record that they will not be back here asking that it be continued.

Any further questions?

Thank you very much, sir. We appreciate your being here.

The CHAIRMAN. Mrs. Emanuel M. Last on behalf of the Virginia Association for Mental Health.

You may proceed, Mrs. Last.

STATEMENT OF MRS. EMANUEL M. LAST, LEGISLATIVE CHAIRMAN, VIRGINIA ASSOCIATION FOR MENTAL HEALTH

Mrs. LAST. I thank you so much for the opportunity.

The Virginia Association for Mental Health has realized the need for local treatment of mental illness. We recognize the need for the Federal Government to aid in the establishment of the community mental health centers.

We were enthusiastic when the bill for establishing the mental health centers was brought before Congress. Unfortunately, the bill as it passed provided funds for buildings only. We are here today to ask your support for the passage of H.R. 2985 which will allow the original intent of the Mental Retardation Facilities and Community Mental Health Centers Construction Act. The following resolution was passed unanimously by the delegate assembly of the Virginia Association for Mental Health.

Whereas the Virginia Association for Mental Health has long been vitally concerned with the establishment of community mental health centers for the care, treatment, and rehabilitation of the unfortunate mentally ill; and

Whereas the Virginia Association for Mental Health fully realizes that said community centers cannot and will not accomplish the true purpose of said centers without sufficient staffing by competent and experienced staff members: Be it

Resolved, That the Virginia Association for Mental Health in convention assembled this 26th day of February 1965, gives full support to House bill 2985, introduced by Congressman Harris, of Arkansas, on January 18, 1965; and further

Goes on record in full support of President Johnson's message of January 7, 1965, recommending initial costs of personnel for the staffing of said community mental health centers.

Thank you so much for the privilege of appearing before you. And any time you want to ask me questions, I will be very glad to come back when my transportation isn't pressing.

But I know you will be relieved not to ask them.

The CHAIRMAN. Gentlemen, with that admonition, does anyone have any questions?

Thank you very much, Mrs. Last. We are glad to have your statement. You may be excused.

Next we will hear Dr. Addison M. Duval, who is a director of the Division of Mental Health, Georgia Department of Public Health, Atlanta, who is here representing the American Psychiatric Association.

STATEMENT OF ADDISON M. DUVAL, M.D., DIRECTOR, DIVISION OF MENTAL HEALTH, GEORGIA DEPARTMENT OF PUBLIC HEALTH, ATLANTA, GA., AND VICE PRESIDENT AND COUNCILOR, THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. DUVAL. With your permission, Mr. Chairman, I would simply like to submit the statement we have prepared setting forth the position of the American Psychiatric Association with regard to our interest in the passage of H.R. 2985.

We are a professional association of some 14,000 psychiatrists across the Nation. We have through the council, the executive council of this association, unanimously endorsed this proposal. And we believe that the passage of this legislation is necessary to the development of proper, modern treatment methods in the various States of the Nation.

I have other comments, sir, if you would permit me to make them.

The CHAIRMAN. Doctor, your statement as presented to us, which we have here for our perusal and study and benefit, will be included in the record in full.

(The prepared statement of Dr. Duval is as follows:)

TESTIMONY IN SUPPORT OF H.R. 2985 ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION, BY ADDISON M. DUVAL, M.D., VICE PRESIDENT, COUNCILOR, AND FORMER TREASURER OF THE ASSOCIATION; DIRECTOR, DIVISION OF MENTAL HEALTH, GEORGIA DEPARTMENT OF PUBLIC HEALTH, ATLANTA

Mr. Chairman and gentlemen of the committee, I am honored to have this opportunity to speak to you today in support of the farseeing legislation which has been introduced in the House by your distinguished chairman, Mr. Harris, to assist in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers. In doing so I am proud to represent the American Psychiatric Association, which is wholeheartedly behind this proposal.

If I may inject just a brief personal note: I have spent my entire professional career in psychiatry in public mental health and hospital work. I was at St. Elizabeths Hospital here for 30 years, then director of mental hygiene for Missouri, and now I direct the mental health program in Georgia's Department of Public Health. I feel that this experience positions me as well as anyone to pay tribute to the U.S. Congress for having imparted to those of us on the firing line in the battle against mental illness a surge of hope and optimism that our profession has not experienced since the days of Dorothea Dix before the War Between the States.

It was the Congress that established the National Institute of Mental Health in 1946 with all that that has meant for the advancement of training and research in the mental health disciplines. It was the Congress that championed "medical care second to none" in the Veterans' Administration after World War II and thus made possible the evolution of standards of psychiatric care in VA hospitals never achieved theretofore in public facilities. It was the Congress that made possible the work of the Joint Commission on Mental Illness and Health by passing the Mental Health Study Act of 1955 which led to that stirring report "Action for Mental Health" in 1961. It was the Congress that responded to that report by appropriating over \$8 million 2 years ago to help the States start planning comprehensive programs that will enable us to realize what President Kennedy came to call a "wholly new approach" to mental illness—an approach that would bring the mentally ill into the mainstream of medicine; and it was the Congress that in 1963 passed Public Law 88-164 providing construction money to help the States to build some of the new comprehensive community mental health centers which form the heart of a wholly new approach.

As one steeped in the history of custodial care for the mentally ill in America, and as one who has spent the better part of four decades striking blows wherever I could in behalf of a better approach, I can say in all honesty that it was not until the Congress began to share in our problems in the ways I have mentioned here that I began to entertain hope of success in overcoming this massive health problem.

Gentlemen, in my judgment, you have brought us to the threshold of victory. Now it is for us in psychiatry and the other mental health disciplines who have the most direct responsibility for coping with mental illness to ask you to go yet another mile. Push us over that threshold. You can do it by passing this legislation. The bricks that you provided in Public Law 88-164 are fine, and desperately needed. But they are not enough. We've got to draw a basic cadre of brains into our new comprehensive community services to get the show on the road.

Gentlemen, it isn't as though we hadn't tried to do this job without the Federal assistance we are now seeking. We have tried throughout our history. We are trying now. We have made some headway, as I will presently demonstrate. But try as we will, I cannot see, and my colleagues cannot see, how we can work up an initial head of steam without some of the fuel that only the Congress can provide.

Last year our association, in cooperation with the National Association for Mental Health, made a survey of existing community mental health centers throughout the country and we discovered that there were 234 facilities that had some of the elements of a community mental health center. Some of them operated principally as outpatient clinics and emergency services. A smaller number offered inpatient services. A few provided consultation services to other agencies in the community. But only a handful, of course, could be described as offering a truly comprehensive community mental health service within the meaning of the term as described in the regulations drawn up by the Department

of Health, Education, and Welfare as directed in Public Law 88-164. I merely want to point out that the community services idea has long since caught on with the professionals and enlightened citizens in communities throughout the land. We are trying hard, but progress is often at a snail's pace primarily because of the staffing problem.

There were about 50 community centers in our study, however, that did offer comprehensive services. They are found, as one might expect, mostly in those States which have long since launched community mental health services programs as a matter of policy such as New York, California, and Illinois.

These centers which are now effective, going concerns may be viewed as the prototypes of the 1,000 or so comprehensive community centers with which we hope ultimately to blanket the country, the objective being to have each center serve a population of between 75,000 and 200,000 people. We hope we can achieve 500 of them by about 1970.

So we have a long way to go, and the point I wish to make here is that we have made a start. We have demonstrated that the "wholly new approach" works wherever it has been tried. I am reminded of Mr. Churchill's comment after Rommel's defeat in North Africa to the effect that one could not speak of it as the end, or even as the beginning of the end, but it was, perhaps, the end of the beginning. And that is the way I feel about what we have accomplished thus far.

Even in these going programs, however, the staffing problem is a critical one across the board. We must remember here that we are dealing with a new type of service. There must be a reasonable ratio of staff to patients if one is to operate a day hospital, a night hospital, an inpatient service, an emergency service, and consultation and information services to the community at large. The ratios called for in existing standards for mental hospitals simply will not do. The comprehensive community-based psychiatric center is quite a different proposition.

In the few outstanding centers I have mentioned the problem is not so much attracting personnel—except, perhaps, in rural areas. These centers are carrying on the kind of exciting program that appeals to young people—trainees in psychiatry, social work, psychology, and nursing. It is retaining staff that is so difficult because, by and large, salaries are simply not competitive. In place after place we were told that salaries for professionals run well below prevailing income for private practice, and at most places salaries for aids, clerical employees, and kitchen workers are lower than for similar work in the community. As Dr. Joseph Downing of the San Mateo County Mental Health Services in California said: "Our psychologists are paid less than privately practicing plumbers." Dr. Alan Kraft of the Fort Logan Mental Health Center told us: "Under the State civil service system there is no provision for offering special inducements. * * * Our major inducement is the opportunity to participate in and to help mold and develop and refine a completely new psychiatric program."

I think Dr. Kraft has stated the essence of the matter, gentlemen: People are attracted to these lively programs, but they cannot be expected to stay indefinitely unless something can be done to make their salaries reasonably competitive with other opportunities. We have here grounds for plenty of optimism about the appeal of the centers, dampened only by our failure to remedy a situation which is correctable by way of making the salaries we offer more competitive. And one way to start correcting it is for the Federal Government to join with the States and communities in sharing the costs of doing so until a pattern gets established which can be taken over by the States and communities.

But thus far I have spoken only of the problems confronted by those 50 comprehensive community centers now in operation. What can be said of the others in the 234 facilities that we counted which are barely getting off the ground? And what can be said of the 500 centers we hope to have by 1970, and the 1,000 centers we will ultimately need? Surely, it takes no stretch of the imagination to project that there must be Federal sharing in the cost of staffing these centers in their first years of operation if we are going to approach our goal with any real confidence of success this side of the year 2000. And let me interject at this point that one of the finest features of this legislation is the provision it makes for lending assistance to establish new services in existing centers. This is going to be of enormous help to those budding centers which already have one or more of the elements of comprehensive service. It will give them the added boost they need to become full fledged community mental health centers in the context we are talking about.

Now the very attempt to adequately staff 500 mental health centers in the foreseeable future seems fantastic and ludicrous to some people. But my col-

leagues and I in the American Psychiatric Association neither feel nor counsel despair in facing up to the challenge. It isn't as though we can't lick this manpower problem, given the national will to do it. We licked it in World War II. We are even licking it in the space field, and we can lick it in mental health. Admittedly, the problem is complex, with ramifications into our entire educational system, the cultural values which we acquire about the choice of a career, the changing roles and better utilization of the personnel we have available, and all those things. But the heart of the matter boils down to this. If you want people you've got to do three things: You've got to recruit them; you've got to train them; and then you hire them at competitive salaries. We've got to do these things all at the same time and it takes more money than States and communities have to get this massive undertaking started.

So far as recruiting is concerned, I simply do not believe that this is going to be a fundamental problem in the long run. This is a matter for the professional disciplines to solve in manifold ways. We can, we are, and we will do an even better job of orienting young people in our disciplines to the exciting new opportunities that await them in community service. Speaking for my own profession, we are turning out about 800 new psychiatrists every year, and our task is to help ensure that an ever-greater percentage of them will turn from interest in private practice to a broader application of their clinical skills in comprehensive community services. We are doing this now in our medical schools and in graduate training; and we will do better.

In fact, what impresses me is not how impossible the outlook is, but how much progress we have made already. Largely because of the Congress' support of the National Institute of Mental Health training grant program, the number of people in training in the disciplines of psychiatry, clinical psychology, social work, and nursing increased from 12,000 to 44,000 in the decade of the fifties. The same agency was given funds back in 1958 to help train nonpsychiatrist physicians in psychiatry, and since then at least 12,000 such physicians have received such training, and better than that, over 500 of them have gone on to complete a full residency in psychiatry. There's nothing discouraging about that.

Dr. Robert Felix has stated that we will need about 22,000 workers in the core professions to staff the community centers we hope to see built by 1970. Well, if we gained some 32,000 people in these disciplines in the 1950's what's to prevent us from doing an even better job in the 1960's and 1970's? Isn't it just a matter of making the funds available to insure that no young person who is qualified and who wants to join our ranks is deprived of training for lack of financing? I understand that last year the National Advisory Mental Health Council had to reject qualified applicants for training stipends to the tune of \$10 million which had not been appropriated; and it is projected that in 1965 the Council will fall short by about \$12 million of training funds which it could put to good use. If we really mean business about this wholly new approach, it seems to me that this makes no sense. To fail to spend \$10 million for training young people in a given year is simply to lose about 1,400 individuals from our ranks. I suggest this is no way to walk boldly into the future. It betokens some kind of ambivalence in our national policy. I would hope that the Congress in its wisdom will this year correct the situation forthwith.

Yes, I think we can take care of the recruiting situation in our own ranks. And we can take care of the training situation with your help. Then there is the problem of hiring people, and we can take care of that, too, if only the Congress will help us get off the ground in the first years of putting the new community centers into operation. That is why it is so important, as we see it, to pass this bill now before the House.

Gentlemen, we are not talking here about billions of dollars, unless we want to reflect on the value of the man-hours that are lost to our national economy because of mental disorders. We aren't trying to compete for priority over roads, schools, national defense, or the antipoverty program. We aren't asking you to put us on the moon by 1970. We are asking you to lend us a hand to the tune of a little over \$300 million spread over the next 5 years, starting with less than \$20 million in fiscal 1966 and terminating at the level of about \$105 million in 1970. And we aren't asking you to assume the entire burden by any means, but only to share temporarily in the cost of getting many of these new centers underway by 1970. Gentlemen, if you will make this modest investment to back us up, the payoff for the Nation is going to be tremendous.

Think of what the community general hospital psychiatric units have accomplished already in the past 20 years. Nearly 20 percent of general hospitals now offer some kind of psychiatric treatment service (almost 1,000 of them) and in 1963 they treated well over 400,000 mental patients. Twenty years ago, three out of

four mental patients who received any treatment at all received treatment in a tax-supported State hospital. Now, however, the State hospital cares for only one in four mental patients and today two out of every three mental patients are being treated on an outpatient basis and the majority of them in the private sector of medicine—in general hospitals, private psychiatric hospitals, and by private practitioners.

No, gentlemen, I submit that we haven't been sitting on our hands waiting for a handout from the Congress. We have demonstrated beyond any shadow of doubt that it is possible to rid ourselves of the custodial care of the past; it is possible to give every citizen in this country adequate care for mental disorders, promptly, at the right time, and at the right place, in his own community. And I think—I hope—that this is the year of national consensus and decision. I think there is a ground swell of support for the measure we are recommending.

Just 2 weeks ago the American Psychiatric Association convened a conference of nearly five hundred key leaders in State mental health planning organizations at the Sheraton Park Hotel here in Washington. They represented well over 30,000 citizens in communities throughout the Nation who have become involved in this planning process since the Congress appropriated funds nearly 2 years ago to get it underway. We thought the time was right to bring them together so that all of us could hear about the progress they had made, the hopes they entertained, and the realities they faced.

I wish all of you could have been there. Mr. Harris was there and he did us a real good turn when he said in so many words: "I hope we can get this bill passed but I want you to know that it is highly controversial and you'd better get busy and muster all the support you can find for it in every nook and cranny of this land." Mr. Fogarty was there and cheered our hearts again because he has championed our cause, for these many years and we love him. The same goes for Senators Lister Hill and Sam J. Ervin. Secretary Celebrezze was there and so were Governors Kerner and Volpe. Mr. Walther Reuther at the last moment couldn't come but he sent a message to be read by one of his colleagues and that message was loud and clear, and one that we liked. The professions of psychology, social work, and nursing were there, as were clergymen of all faiths; and plenty of others; and I can tell you there was no note of discord in this distinguished gathering. And this was no cut-and-dried audience of psychiatrists. It was representative of a broad cross-section of the citizens who have struggled hard, helped by the money you have appropriated, to come up with some sensible plans as to how they are going to materialize comprehensive community mental health services in their States. In the final moments of their meeting they expressed their consensus with this resolution, and I quote:

"Be it Resolved That this conference:

"1. Seconds President Johnson's recommendation to the Congress that Federal assistance be provided for the staffing of community mental health centers;

"2. Endorse Senate bill S. 513 and H.R. 2985 to implement the President's recommendation, and

"3. Urges that a coordinated and sustained effort be initiated by the American Psychiatric Association, aided by the National Association for Mental Health, and similarly dedicated groups and individuals, to develop a national consensus of support so as to make possible the achievement of our common national goal of adequate community mental health services for all citizens."

This resolution was passed by "acclamation," a somewhat more accurate word than "unanimous" because there was one single hardy soul in the group who voted "nay."

Gentlemen, in conclusion, I think we can muster that consensus of support this year. We are going to take Mr. Harris' constructive advice to heart and do our best. We in the mental health professions feel that we can't afford to spend another year trying to rally support for this critical decision by the Congress. Not that we won't do it if we have to; but we don't want to spend our time that way. We want to get on with the job of making the wholly new approach a reality. We hope that this will be your year of decision, that you will go another mile with us that we may then walk by ourselves with surer foot, and more briskly and confidently into a new day for the mentally ill of America.

Dr. DUVAL. Thank you, sir.

I would like to make one very brief additional statement. You have, Mr. Chairman, a telegram to you from our progressive Governor, Carl Sanders of Georgia, actively supporting this legislation also. And being from Georgia, I would like to mention that here and to indicate

to you and to the committee that Georgia is one of those States that got a late start in its progress toward the improvement of its mental health programs. Only about 5 years ago, did the State really start such a movement. We have made enormous improvements by the expenditure of millions of dollars on this program already.

One of the keystones of our future progress, we believe, is a program which is now almost complete for the building of a new Georgia Mental Health Institute in Mr. Mackay's home district and county, where we propose to train for the State the major part of our future needs in the way of professional staff for our community mental health programs.

And, secondly, we are almost ready to break ground on a new mental retardation center in Atlanta which will provide the training and education in the field of mental retardation.

So that we are already in the State exercising a major effort in improvement. And we do believe that the passage of this legislation would give us a lift over the next few years in this very difficult period which is ahead of us.

With that, sir, I would conclude my remarks.

The CHAIRMAN. If you have a copy of the telegram you referred to from Governor Sanders you may submit it, and it will be included in the record at this point.

Dr. DUVAL. Thank you. I am happy to submit it.

(The telegram referred to is as follows:)

MARCH 2, 1965.

Hon. OREN HARRIS,
*Chairman, Interstate and Foreign Commerce Committee,
U.S. House of Representatives, Washington, D.C.:*

We support and urge approval for Federal grants to the States for the purpose of staffing mental health centers as provided in H.R. 2985. Such grants are essential for the development of services necessary for the mentally ill. I hope you and your committee can look favorably on this bill.

CARL E. SANDERS,
Governor, State of Georgia.

Copy to: Hon. James Mackay, U.S. House of Representatives, Washington, D.C.

The CHAIRMAN. Thank you, Dr. Duval. We are sorry you have to leave right away. But it takes quite awhile to get to Dulles.

First, does someone have a special question he wants to ask of Dr. Duval?

Mr. NELSEN. One question, Mr. Chairman.

The CHAIRMAN. Yes.

Mr. NELSEN. Were you able to get personnel for staffing, are they available, have they been trained? Is there a supply of staffing personnel?

Mr. DUVAL. We have a small supply which is being graduated from our two medical schools in our clinical psychiatric work. But we propose to increase this number by these two training centers which I mentioned. The first of these will be in operation within the next 6 months, and the second one a little later than that. So we basically propose to train our own rather than try to take them away from others.

Mr. NELSEN. The reason I made the point is, in title III of the bill that we passed, it provided for the training of expertise to go in to the assistance in these hospitals and it seemed at that time that the

personnel was not available, and there was a great need for personnel training to be made available to the States. And that was why I asked the question.

Dr. DUVAL. That still is a very major part of the difficulty.

Mr. NELSEN. Thank you very much.

The CHAIRMAN. Anyone else?

Mr. Mackay?

Mr. MACKAY. Mr. Chairman, I would just like to say that I think the willingness of a man of Dr. Duval's stature to come to Georgia is the best evidence that we have of the commitment of the State in this field. And I would hope that at least some members of this committee could visit our State and see the transition we are making from a big warehouse-type hospital to the community health center. I am very proud to have him here.

I might say that I feel very reinforced today, because I am very glad to have Congressman Howard Callaway, from Georgia, join the committee. I know that he shares with me my pride in having Dr. Duval here.

The CHAIRMAN. I would like very much to go to the gentleman's State and observe the situation as it is. But if it develops that I am unable to go, I would be glad to designate you and Mr. Callaway for that purpose.

Mr. MACKAY. I would love to go.

Dr. DUVAL. I hope that you will come after September 1 when this fine new training center will be in operation, Mr. Chairman.

The CHAIRMAN. Mr. Callaway?

Mr. CALLAWAY. No questions, Mr. Chairman, except to echo what my colleague, Mr. Mackay, has said in commending the progress of our State.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Doctor, on page 6 you estimate the need—and I take it that this is an estimation of your association nationwide—\$300 million over a period of 5 years.

Dr. DUVAL. Yes, sir.

Mr. YOUNGER. How carefully was that estimate made?

Dr. DUVAL. I wouldn't be able to say, sir, that it is more than an estimate. But it did receive a good deal of attention and study.

Mr. YOUNGER. Did you discuss the limitation with the HEW or is it just your own?

Dr. DUVAL. I understand, sir, that this discussion was carried on informally.

Mr. YOUNGER. And this might represent their views also?

Dr. DUVAL. I wouldn't want to assure you that it did, sir.

Mr. YOUNGER. That is all, sir.

The CHAIRMAN. Thank you very much, Doctor. We are glad to have you with us. We appreciate your contribution to this program.

Dr. Dempsey, you and Dr. Terry, have been here all day. Will you come back up? I am not sure if the members have any questions, but I do want to give them an opportunity if they do have. And in view of what was asked yesterday, I do want to give you a further opportunity to make any comments you wish to make.

Dr. Dempsey?

STATEMENT OF EDWARD W. DEMPSEY, PH. D., SPECIAL ASSISTANT
TO THE SECRETARY (HEALTH AND MEDICAL AFFAIRS), DE-
PARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOM-
PANIED BY LUTHER TERRY, M.D., SURGEON GENERAL, U.S.
PUBLIC HEALTH SERVICE—Resumed

Dr. DEMPSEY. Mr. Chairman, I would like to make a comment relative to some of the questions that were asked about the Department's attitude—

The CHAIRMAN. I think probably if you are going to comment on other's testimonies, we will let you come back later after we are all through with this. That is usually the way we do that. I do not want to use this time in hearing comments on the record that has been made thus far.

Usually our procedure is to wait until we conclude, and then we will give you an opportunity, as Dr. Terry knows very well, to come back for any further questions that the committee might have in view of what has been developed during the course of the hearing.

But I would like to say in carrying out the thought that Mr. Younger had a moment ago, Dr. Terry, that I wish you get for the committee and the record the information as so the estimated cost insofar as you are able so tell at this time for the 4 years and 3 months of this program. You have already given us the first year, which would be \$19.5 million, or 65 centers. For the next 4 years, or 3½ years, obviously you could give us the benefit of what you think at this time might result in each of the years for the use of the committee. Could you do that?

Dr. TERRY. Yes, Mr. Chairman. Secretary Celebrezze has indicated that the Department would be glad to do this, and we are working on it at the present time, and we will submit it shortly to you, sir.

The CHAIRMAN. If you will do that, including the breakdown of the personnel as we asked of the Secretary, I think it would be helpful for the committee.

Dr. TERRY. Yes, sir.

(NOTE.—The information referred to appears on p. 48.)

Mr. MACKAY. Mr. Chairman, I wonder if the chairman would clarify for the benefit of us beginners the term "open-end appropriation" that Mr. Springer used.

The CHAIRMAN. Yes. If you will refer to H.R. 2985, and turn to page 5, section 224 states:

There is authorized to be appropriated for each fiscal year beginning after June 30, 1965, such sums as may be necessary to carry out the purposes of this part.

In other words, it is not a fixed authorization it is a blank amount, and therefore it is referred to as an open amount. If it read "There is authorized to be appropriated for each fiscal year beginning after June 30, 1965, the sum of \$19,500,000 for the first year, and \$55 million for the second, and so on," that would have been a fixed authorization.

Mr. MACKAY. This was a question that I wanted to ask either of these gentlemen. Under the Interstate Highway System, as I understand it, we have a fixed formula of State-Federal participation, 90-10. As I understand this, the distribution could be based on any formula that might be agreed upon up to 100 percent financed.

The CHAIRMAN. We have a fixed formula in this program too. In this bill the first year the contribution would 75-25, the second year 60-40, and the third year 45-55, and the final year, 30-70.

Mr. MACKAY. Then the theory of this is not to equal the resources of the State, it would be the same for every State regardless of the actual wealth of that State?

The CHAIRMAN. Of course, we will get into these discussions among the committee members later on, and we will probably have a good deal of discussion. But I would say that Dr. Dempsey and Dr. Terry could probably explain it with much more clarity than I could.

But the plan here provides for mental health centers to be established at such places within each State as the State plan would provide. And unless and until the State plan is provided and you know what kind of a center it is going to be, you cannot have a fixed or a definite authorization for it. And for that reason it is estimated from the reports that are out all over the country that the establishment of this program will ultimately result in an x number of centers. And those x number of centers—and I don't think they use a computer on this, but it is probably the same thing—would turn out in the end to be x number of dollars of the total program at cost, but you could not tell precisely where it would go until this further information is released.

Now, did I state it correctly?

Dr. DEMPSEY. That is an excellent summary, I think.

Mr. MACKAY. That leads to one final question. Governor Kerner this morning talked about the fact that his resources were far superior to the resources in some of the States to which he must send mentally ill people or return mentally ill people. This bill does not guarantee any evenness of the achievement of the mental health program in the United States as a whole. It simply offers an opportunity to each State, and if the State or the legislature of the State makes the judgment that it is not interested, then this Federal program really goes by the board in that State.

Wouldn't that be correct?

Dr. DEMPSEY. That is correct. If the State had no interest in establishing such a program, there is nothing in this bill that would force it to do so.

Mr. MACKAY. It is a local option bill, isn't it?

Dr. DEMPSEY. Yes, sir.

Mr. MACKAY. Kerr-Mills wasn't financed 100 percent in my State, and you wouldn't get the benefit of that program.

Dr. DEMPSEY. My understanding is that in the United States in communities in which the maximum ability and interest exists to mount the program now, that projects could be placed there under local option; yes, sir.

Mr. MACKAY. I guess this is the way it has to be done, Mr. Chairman, if you are going to keep the real emphasis in the States and avoid just a federally directed program. But it certainly has an uneven result.

The CHAIRMAN. I think probably you will find when you get into the record that the need that exists as far as the country is concerned is most uneven itself. I know in my own State at certain times they have a greater need in one section of one area than you have at other times. And that is the reason they are concentrating on these areas within the State to try to establish local centers where they can reach the greatest number of people for that purpose.

It is similar to our airport program. That is a most uneven type of program because in the highly concentrated areas the need is so much greater. The formula we have for the allocation of funds for airport construction is so outmoded to date that it simply does not meet the problem. The last time we extended that program we had to modify the formula in order to meet just what the gentleman is talking about, the national need.

Mr. MACKAY. No further questions.

The CHAIRMAN. Does anyone have any further questions?

I have forgotten who was asking questions of Dr. Dempsey.

Dr. DEMPSEY. Mr. Rogers, I believe.

The CHAIRMAN. He isn't here.

Mr. Farnsley.

Mr. FARNSLEY. My distinguished colleague from California asked the question very unselfishly, but I ask the same question very selfishly. Kentucky is 46th in per capita income. So it occurs to me that it would be nice if we could do this. Say you were going to give so much per capita to the State for each citizen, so many dollars for the State's rank in per capita property, then Kentucky would get \$46. Is there any way we can do this?

Dr. DEMPSEY. As the bill is written, it is for projects to be applied for by applicants rather than on a formula basis. So that we did not contemplate in the bill a formula distribution among the States.

Mr. FARNSLEY. Put in a plug to the Secretary for me.

The CHAIRMAN. Doctor, I think there is something to this whole idea. If you don't have an estimated amount of funds available for the program as it proceeds, I can understand why the Department might, as Mr. Younger mentioned earlier today, allocate a greater proportion to one State, even beyond the comparative needs that you would have in another State. Now, how are you going to meet that problem?

Dr. DEMPSEY. The mechanism that has been used over and over by the Public Health Service in equalizing its programs to the best of its professional ability is for the review of applications by professionally qualified people. We will certainly have operating within this program, as with others, a review to assure that the money will go to the places where it does the most good.

The CHAIRMAN. Are you asking for enough? Is it proposed here that you will have sufficient authorization under the program to provide for the same needs all over the country as you know these needs to be?

Dr. DEMPSEY. I can only answer that by saying that the first-year estimates are as accurate as it is possible to make at this time.

The CHAIRMAN. And do you think that those needs will be fairly evenly distributed in accordance with the indications that you have had from the States as to what they would like to do and what they will be able to do?

Dr. DEMPSEY. As I tried to indicate to you, they will not be evenly distributed according to the need of the population of the State, but they will be distributed evenly, according to the ability of the States to man the programs at the particular time.

The CHAIRMAN. I think it ought to be considered on, No. 1, the basis of the ability of the State to meet it; No. 2, the need that exists as to the number of people afflicted in that State, not necessarily the

total population, but the need of those to receive the treatment, and then No. 3, the ability to meet that need.

Dr. DEMPSEY. The bill calls for the development of a comprehensive plan by the States in which the need of the States is one of the factors. I believe Dr. Yolles testified that he expected all 50 of the States to have filed this plan by the deadline.

The CHAIRMAN. Mr. Farnsley, I didn't intend to take over from you.

Mr. FARNSLEY. No. I am through, Mr. Chairman.

The CHAIRMAN. Any further questions?

Mr. BROYHILL. Referring to H.R. 2984, I wonder if you could give by reference a source of the description of the health research facilities that the Department has constructed in the past, and is proposing for the future. Do you have such report in the Department that has been prepared in the past, so that we can just have the reference in the record?

Dr. DEMPSEY. I am sorry, I don't know at the moment whether there is such a prepared report. In my testimony I believe that I said that over the program's lifetime there had been 399 projects. I can get you a listing of those, and we will be glad to submit it for the record.

Mr. BROYHILL. I am not asking that it be submitted for the record, I would just like to have it in by reference only.

Chairman HARRIS. You can submit it for the file.

(NOTE.—The information referred to was submitted for the committee files as the Ninth Annual Report of the Surgeon General of the Public Health Service on Health Research Facilities.)

Mr. HARVEY. Dr. Dempsey, I would like to refer to 2987 for just a minute with regard to the loans and mortgage insurance by the Surgeon General. And I wondered whether your office considered as an alternative amending our housing laws rather than having it—was that alternative considered?

Dr. DEMPSEY. It was considered; yes, sir. And the decision was made to take this route rather than the other one, for the reason that we believe that with a health facility in which there will be housed a considerable number of doctors of varying kinds of specialties and with equipment that must be adequate for the activities of those specialties, that all of these considerations indicated the health component in this program to be so great that it was more appropriate for a health-related, health-interested agency to undertake the program than it would be for a housing agency.

Mr. HARVEY. Let me ask this next question, then. Does the Surgeon General, in the course of his duties, make any other real estate loans of any kind whatsoever?

Dr. TERRY. No, sir.

Mr. BROYHILL. Does the Surgeon General, in the course of his duties, want to change that?

Dr. TERRY. Yes; I do wish to change it. There is a provision whereby loans may be made through the Hill-Burton program under certain circumstances. I believe that is the only one.

Mr. BROYHILL. If I am correct, though—and you correct me if I am wrong—the loans under Hill-Burton are not real estate loans as such, are they? In other words, they aren't loans where you would go out and appraise a piece of real estate?

Dr. TERRY. They are loans to assist in the construction of health facilities.

Mr. BROYHILL. And you are personally responsible for that, are you?

Dr. TERRY. Yes, sir; I have the responsibility for that.

Mr. BROYHILL. And is there any function in the Surgeon General's office of issuing mortgage insurance as such?

Dr. TERRY. No, sir.

Mr. BROYHILL. So this would be your first venture into the mortgage insurance field, is that correct?

Dr. TERRY. That is right.

Mr. BROYHILL. Dr. Terry, maybe you can help me. I was looking at page 20 of the statement by Dr. Dempsey here, and on page 20 it speaks of these loans:

Such loans would only be made if the Surgeon General found that the applicant is responsible and able to repay the loan but is unable to secure the amount thereof from other sources upon terms and conditions as favorable as the terms and conditions applicable to the loans secured by mortgages insured by the Surgeon General.

That is section 902 that we are talking about, is that correct?

Dr. TERRY. Yes, sir.

Mr. BROYHILL. On page 4, I guess it would be, of 2987. I just want to be sure I understand that correctly. So what you are asking is authorization to make real estate loans with maturity up to 25 years, and with interest rates to 5 percent, and in some cases, I take it, up to 6 percent, is that correct?

Dr. TERRY. That is correct, sir.

Mr. BROYHILL. Is there any evidence that you have across the country that doctors at the present time are unable to get these loans?

Dr. TERRY. Yes, sir; we have had a considerable expression to us in terms of the needs in this direction, particularly from the smaller, newly starting groups.

Mr. BROYHILL. Do you mean to tell me that you have doctors who said they have gone to banks and savings and loan institutions and have been turned down on real estate loans of any kind whatsoever?

Dr. TERRY. I don't know that they have been turned down. But either the circumstances were sufficiently unfavorable, or, because of something of this nature, they didn't feel that satisfactory loans were available.

Mr. BROYHILL. Do you have specific instances of that, that you could give us here for the benefit of the committee, either that you have with you or that you could send us to be included in the record, instances of physicians who have been turned down for real estate loans?

I say that, Doctor, because maybe the State of Michigan is different from the part of the country you are speaking of, but in Michigan doctors have a prime responsibility, and they are considered exceptionally good risks. And I can tell you that the youngest graduate or a medical school can walk into a bank and secure a loan with the longest maturity and the lowest interest rate of anybody in the community. And I would be very surprised if it were otherwise across the country. I would like to know if it is.

Dr. TERRY. I will try to see what specific information I can get and present it to the committee.

(Dr. Terry later submitted the following information:)

STATEMENT OF NEEDS FOR LOANS

A review of our files discloses no evidence of an unmet need for loans or mortgages on the part of practicing physicians. At the same time, there is considerable evidence that nonmedical groups, in attempting to establish programs which would provide medical and health services through prepayment schemes, have had considerable difficulty—specifically, the Health Insurance Plan of Greater New York, affiliates of the Group Health Association of America, and the Kaiser-Permanente Foundation.

Mr. BROYHILL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Then I would like to have you come back for further discussions in these matters with the committee.

Does anybody else have any questions?

If not, Dr. Appel and Dr. Long, we will hear you next.

STATEMENT OF JAMES Z. APPEL, M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY ROBERT C. LONG, M.D., MEMBER, BOARD OF TRUSTEES, AND ERNEST B. HOWARD, M.D., ASSISTANT EXECUTIVE VICE PRESIDENT

Dr. APPEL. Mr. Chairman and members of the committee, I am Dr. James Z. Appel, of Lancaster, Pa., where I am in the general practice of medicine and surgery. I have recently been honored by my colleagues by being elected to the office of president-elect of the American Medical Association and, when inaugurated this June, I will become the association's 120th president. With me today to assist in presenting the testimony of the AMA, are Dr. Robert C. Long, a member of the AMA board of trustees who is a practitioner of obstetrics and gynecology, and who is an assistant clinical professor of obstetrics and gynecology at the University of Louisville, and on my right, Dr. Ernest B. Howard, who is the assistant executive vice president of the American Medical Association.

I want to thank you, Mr. Chairman. We feel that it is a great privilege to appear before your committee, which through the years has been instrumental in the development of sound and necessary health legislation. We have appeared before you many times. We have come to recognize this committee to be one of the most important in the field of health. I repeat, Mr. Chairman, we are grateful for the opportunity to be here today. We look forward to being here again many times in the future.

We are here today, however, to present the opinion of the AMA on four measures which intrinsically involve the health of the public. We trust that our comment will assist the committee and will be of value in your deliberations.

I would like to turn my attention now to H.R. 2986.

As we understand H.R. 2986, the Community Health Services Extension Amendments of 1965, the Vaccination Assistance Act would be extended for 5 years. The program of family health service clinics for migratory workers would similarly be extended for 5 years, and both the Community Health Services and Facilities Act of 1961 and the special project grants program for community health services would be extended for a 1-year period.

Three years ago, the American Medical Association urged that the Congress enact legislation which would enable States and communities

to carry out intensive vaccination programs for young children. Today, the association again supports this legislation.

Medicine, on the National, State, county, and community levels, has consistently worked to bring to its patients the benefit of advances in medical research and development. The physicians of America and the Public Health Service have long been partners in the fight against disease and in the campaign to eradicate contagious disease wherever it is found.

The Vaccination Assistance Act of 1962 was enacted in recognition of the fact that there existed all over the country pockets of people, particularly children, who were not utilizing, or who did not have available to them, vaccines for the prevention of poliomyelitis, diphtheria, whooping cough, and tetanus. The act authorizes grants to the States to enable them to engage in a concentrated campaign to provide immunization to people in these pockets. We believe that substantial progress has been made, and we recommend the program's continuation.

In supporting the legislation which led to the enactment of the Vaccination Assistance Act of 1962, the AMA suggested that the program be limited to the four named diseases, poliomyelitis, diphtheria, whooping cough, and tetanus. Medical research has since provided an effective vaccine against measles. An intensive vaccination program directed at preschool age children can dramatically lessen the incidence of the disease and reduce or eliminate the serious residual effects which are sometimes attendant with the disease. We therefore believe that it is most fitting that in extending the Vaccination Act, H.R. 2986 include measles in the authorized vaccination programs.

At the time we previously testified, we questioned the advisability of a provision of the bill then under consideration, which would have vested in the Surgeon General plenary authority to extend the program to any and all infectious diseases without seeking further congressional approval. We now question a similar provision in H.R. 2986. We believe that the committee should delete, as it was deleted from the 1962 act, that provision which would authorize the Surgeon General to include in the program other infectious diseases without further congressional approval.

When, and if, other infectious diseases are proven to be susceptible to practical elimination through intensive immunization activities over a limited period of time, the Congress and the several States should have the opportunity to determine the necessity and appropriateness of a new Federal program.

In the interest of further improving the legislative proposal before you, we recommend that H.R. 2986 be modified in one other respect. We believe that the character of the program should continue to be one of an "intensive community" nature. The bill before you would alter the intent of the existing act by striking the words "limited duration" and "intensive community vaccination." Through the years, the AMA has urged that the best means of administering vaccine is in the doctor's office with the family physician vaccinating his patient. We also recognize that immunization against communicable diseases is a public health matter, and that a program for intensive community vaccination at specific periods of time may be of great value in controlling or limiting a disease for which new and

effective vaccines have been developed. We believe continuing the present character of the program will benefit the public by encouraging families to maintain, through their family physician, a continuing immunization program for their children.

Section 3 of H.R. 2086 would extend the grant program for family health service clinics for migratory workers for 5 years. We recognize that migrant families can and do present health problems which are beyond the capacity of some small communities to handle efficiently. The Public Health Service has done excellent work in alleviating these problems, and we recommend that the committee favorably consider the request to extend the program for 5 years.

Sections 4 and 5 of H.R. 2986 would extend for 1 year the provisions of the Public Health Service Act which provide grants for public health training services and special project grants for community health services. Dr. Edward W. Dempsey, Special Assistant to the Secretary (Health and Medical Affairs), Department of Health, Education, and Welfare, in his testimony before this committee earlier this week, indicated that the 1-year extension of these programs would permit the undertaking of a thorough study of the programs carried out under existing authority. The AMA endorses these provisions which would enable the Department of HEW and the Public Health Service to review the existing programs with a view to improving their usefulness.

Now, let me turn to H.R. 2984.

As we understand H.R. 2984, it would extend for 5 years the health research facilities construction program and would authorize the Surgeon General to construct and operate specialized regional or national research facilities. It would also authorize the Surgeon General to enter into research contracts with private contractors, and would authorize the appointment of three additional Assistant Secretaries of Health, Education, and Welfare.

It is our further understanding that since its inception in 1956, the program of matching grants for the construction of health research facilities has resulted in awards to 399 institutions in all 50 States. These awards involve more than 1,200 construction grants with a total in excess of \$300 million.

In his testimony, Dr. Dempsey reported that the existing program has a continuous backlog of applications which have been judged to be sound and important, but which cannot be financed because of limited funds available under the current authorization. He estimated that the backlog of approved grant applications would reach 80 million by the end of fiscal year 1965.

We agree that the demands and the objectives of the program warrant the approval of the provisions of H.R. 2984 which would extend the program for health research facilities construction for an additional 5 years and which would increase the authorized appropriation to an aggregate amount of \$400 million.

On the other hand, we have studied the section of H.R. 2984 which would authorize a new program for the construction and operation of specialized regional or national facilities, and find serious questions as to the advisability of such an undertaking. Exactly what is sought to be gained?

The need that exists, and which has been pointed out by Dr. Dempsey, is for a means to overcome the existing backlog of justified

and warranted requests for programs for the construction of research facilities. With this point of view we have agreed. But how will this urgent need be met by embarking on an entirely new research construction program?

We fail to see how research can be classified as "regional" or "national" or "local." Research in cancer which may be carried on in a medical school research facility in a midwestern city is as "national" in character as if it were carried on in a city on the west coast. Research in heart disease, or in any of the many areas of interest to medical science, has no geographic bounds. If there are shortcomings, they will not, in our opinion, be remedied by way of a new Federal program which would provide full Federal financing for the construction of health-related research facilities to be operated as directed by the Surgeon General. The remedy, again, lies in augmenting the existing program, which this bill already proposes to do.

We believe that the country will best be served through the utilization of the experience and knowledge of institutions which are currently engaged in medical research. Their record is a good one. We see no reason for beginning a new program which would require many months or years and large sums of money, and which would compete for scarce skilled research manpower, when the same ends may be accomplished by enactment of subsections (a) and (b) of section 2 of the bill. It is our opinion that the proposed new program, rather than having a beneficial effect, would weaken the existing program which has already proved to be effective.

We urge, therefore, that you delete subsection (c) of section 2.

Finally, H.R. 2984 would provide for the elimination of the office of "Special Assistant to the Secretary (Health and Medical Affairs)." At the same time, it would provide for the appointment of three additional Assistant Secretaries of Health, Education, and Welfare. The American Medical Association believes that one of these Assistant Secretaries should be a physician, and urges that such a requirement be specifically spelled out in the law.

Mr. Chairman and members of the committee, with your permission, Dr. Long will continue our testimony and offer the association's comments on the remaining bills. At the conclusion of his presentation, he, Dr. Howard, Dr. Long, and I will attempt to answer any questions which the members of the committee may wish to ask.

The CHAIRMAN. Dr. Long.

Dr. LONG. Thank you, Mr. Chairman.

I wish to express my personal appreciation for your consideration of my transportation schedule. I can assure you, sir, that my patients and my partners will be as appreciative as I am.

Mr. Chairman and members of the committee, before commenting specifically on H.R. 2985, the Community Mental Health Centers Act Amendments of 1965, I would like to invite the committee's attention to the association's testimony on H.R. 3688 and H.R. 3689 before the Subcommittee on Public Health and Safety during the 89th Congress. The provisions of these bills were eventually incorporated into Public Law 88-164, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

On March 28, 1963, Dr. Charles Hudson, a member of the AMA Board of Trustees, recited to the subcommittee some of the association's more recent activities in combating mental illness and promoting

mental health. He told of the study by the AMA's Council on Mental Health which, with the cooperation of the American Psychiatric Association, led to the formation of the Joint Commission on Mental Illness and Health. The study also resulted in the formation of a program which the American Medical Association subsequently adopted as the basis for participation by the association and its constituent societies in the problems of mental illness and health. This program, in its essentials, covered the areas included in the legislation adopted by the 88th Congress. It should be noted, however—and we point with pride to this fact—that the AMA program on mental health was in writing in February 1962, a full year before the introduction of the bills which led to the enactment of Public Law 88-164. We believe that it may be fairly said that much of the thought that went into H.R. 3688, 88th Congress, resulted from information gathered and ideas exchanged at the conference sponsored by the AMA Council on Mental Health and at other meetings held from 1955 to 1962.

Let me briefly summarize some of the essentials of the AMA program on mental health which was formulated and published a year prior to the introduction of legislation on the subject in the last Congress.

We pointed out that there is a demonstrable shortage of adequate mental health services at the community level. We pointed to a need for child guidance clinics, low or variable cost adult psychiatric service, inpatient psychiatric facilities, home-care treatment, day and night hospitals, follow-up clinics, vocational counseling, sheltered workshops, and family counseling.

We urged physician participation in, and support of, prenatal and neonatal care centers, child psychiatric clinics and units in general hospitals, day care centers, and school counseling and guidance services. At the same time, we also recognized a need for expansion of existing facilities in this area.

We stated our support of efforts to provide better standards of care for the institutionalized retarded. In this regard, we further advocated special education programs, day care centers, counseling services for the parents of the retarded child, and a program to provide job opportunities for the retarded adult. And in pursuing these objectives, we noted the need for additional facilities and more properly qualified personnel.

We spoke of juvenile delinquency, of how it continued to be a serious national problem, and urged physicians and local medical societies to become active, or stimulate activity, in the community in this area.

We noted our objection to the use of public mental hospitals or custodial facilities for the nonpsychiatric aged, and suggested greater integration of the aged into community life. For those requiring psychiatric care, we voiced support for the development of new and adequate community facilities staffed by well-trained personnel.

Our program covers the problem of rehabilitation and the need for treatment programs which would enable the individual to function as independently and effectively as possible. It reflects our concern for the problems of alcoholism and narcotic addiction.

Finally, the AMA program includes provisions for education of the physician in mental health, and discusses the problem of an insufficient

number of adequately trained personnel and that of financing community mental health programs. In this respect, the association supports a matching fund program for the development of community mental health services.

Dr. Lindsay E. Beaton, a member of the AMA Council on Mental Health, joined Dr. Hudson in supporting H.R. 3688 and H.R. 3689. He pointed out that the community is the vital center for forward-looking comprehensive programs, that—

We must meet and solve the many problems at the doorstep instead of turning our backs on the isolating the mentally ill. These persons can no longer be treated on an out-of-sight, out-of-mind basis.

As stated, the AMA supported the principal provisions of these measures before the 88th Congress. The association opposed, however, the section of the bill which would have provided matching funds for the initial staffing of the community mental health centers. Our position remains the same today. We believe that once the center has been constructed, the community should assume the remaining responsibility.

The providing of medical care is essentially a community affair. The Federal Government's participation in a matching grant program stimulates the start of the local program and helps the State or community overcome the initial heavy financial burden. Most often, the problem initially facing a community is the one-time large construction-cost expenditure. Assistance here, by way of Federal matching grants, is, in our opinion, appropriate. The funds for staffing, however, should remain the sole responsibility of the local community. There does not appear to be any justification for Federal participation in financing this type of expense, nor is it likely to phase out, as stated in the bill, once the Federal Government has assumed this responsibility. If the community cannot, or will not, support the program from its beginning years, it is not likely to do so later.

There have been some allegations attributing the slow start of the community mental health center program to the lack of funds for salaries of staff. We believe these allegations to be in error. There are a number of factors contributing to the delayed beginning. Not the least of these are the usual problems of geographic location and construction specifications. It is our understanding that most States are currently drafting construction plans which meet the current requirement of assurance of fiscal responsibility. Since Federal funds are not currently available, the only conclusion which may reasonably be drawn is that the States and communities are not delaying the program because of any refusal or inability to provide for the operation of the facility.

Now, Mr. Chairman and members of the committee, I should like to discuss briefly H.R. 2987.

Our final comments are with respect to H.R. 2987, a bill which would authorize mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine and dentistry.

We do not believe that this proposal for Federal subsidy can be justified. Special preference to physicians who will be eligible for the loan or mortgage insurance under this measure can only be supported on the basis that adequate sources of financing do not exist through banks, insurance companies, and other agencies. We know

of no such evidence. It has not been demonstrated that this legislation is required to expand currently available public or private funds to finance or insure the construction and equipping of medical or dental groups. This legislation, and the programs it envisions, are clearly unnecessary and on that basis alone, H.R. 2987 should be rejected by this committee and the Congress.

Beyond the reasons listed above, the bill specifies, in section 905, that the Surgeon General shall give preference to, in effect, closed panel prepaid group health plans. This priority discriminates against other physicians in private practice either as solo practitioners or in partnerships or groups.

We strongly urge that you reject H.R. 2987 as being unnecessary, an unwarranted expenditure of public funds, and a discriminatory bill designed to give certain physicians an advantage not available to others.

Mr. Chairman, the American Medical Association is grateful for this opportunity to present its views on pending health legislation. We hope that our comments will be helpful to the committee. Now, Dr. Appel, Dr. Howard, and I will be pleased to attempt to answer any questions which may be asked.

The CHAIRMAN. Thank you, Dr. Long and Dr. Appel. We want to express our appreciation for your presence here and for your giving the committee the benefit of your views.

These are four important proposals. And since you represent one of the great professions of this country, we are glad to have your express feelings concerning these proposals.

I recall that when we had one of these matters before us in the last Congress we had some difficulty in arriving at a full and complete decision on the same issue. As a matter of fact, I recall that the history was that you had just not arrived during the course of the hearings at any decision as to the staffing of the mental health centers. You explained the viewpoints that prevailed in your organization, but you did not take a positive position at that time.

Later on I was a little bit surprised, and somewhat chagrined, when after we reached a certain point we received a letter in which you opposed this proposal. I assume this position was arrived at by a majority vote like we usually do in this country of the groups and organizations involved.

But I do note that there are no doubt differences of opinion within your own organization, as is the case in many other things in this country. And I assume that that condition still prevails. I attended the meeting of the American Psychiatric Association at the Sheraton Park Hotel, at which there were many doctors from all over the country, and several from my own State.

But the committee will wrestle with this legislation and consider it, and we will try to arrive at a solution which we hope will get these institutions off on a sound basis. We cannot continue the present program under which the States are putting these people all in big State institutions and leaving them there. The costs have gone up in many of the States. I know in my State we have tried to catch up, but we couldn't reach it. And I think we may be on the wrong track, and aren't going at it the right way.

And what I am trying to do is get these programs on a local level and get them distributed over the State so they will be in communities

where the patients' own families can partially take care of them. If that concept can be carried out, I think millions of dollars will be saved, and greater service to these unfortunate people rendered. My experiences over the last year lead me to believe that maybe this will be the right way.

If I shared the viewpoint that Dr. Long just mentioned a moment ago, that there wouldn't be any cutoff, I think it would have an entirely different appeal to me. I agree that this responsibility ought to be at the place where the greatest good and service can be rendered.

You have made a very fine statement of your viewpoint. And certainly we understand and appreciate your position.

Mr. Younger.

Mr. YOUNGER. No questions.

Thank you very much for the advice you have given us.

The CHAIRMAN. Mr. Nelson.

Mr. NELSON. I have an off-the-record question of Dr. Appel.

(Discussion off the record.)

The CHAIRMAN. Mr. Pickle.

Mr. PICKLE. I am sorry I didn't get here for the entire testimony, Doctor. But I think you have some good points here. I haven't heard from any of the physicians in my State that they want this group practice. The question was asked the other morning, who is pushing this. Obviously, if AMA is not pushing it, then where does the support for this community health group bill come from?

Dr. LONG. Congressman, to be sure I understand you, are you referring to H.R. 2984?

Mr. PICKLE. No, H.R. 2987.

Dr. LONG. Where is the support coming from for the financing, limited financing of staffing of mental health community centers?

The CHAIRMAN. He is talking about mortgage loans.

Mr. PICKLE. Mortgage loans and insurance.

Dr. LONG. I don't know where the support is coming from, from what organizations or parts of the country. Perhaps Dr. Appel or Dr. Howard could better tell you. I don't know where it is coming from. But if we can answer that question, there are one or two comments I would like to make about it.

Mr. VAN DEERLIN. If the gentleman would yield, a request for this legislation has come from a prominent constituent who votes in your district, Mr. Pickle, which is why we are holding hearings on it.

Mr. PICKLE. This may be. I haven't been advised that that was so.

As I understand it, under H.R. 2987 a nonprofit group, a charitable or religious organization, could qualify for one of these group setups, and under normal circumstances I suppose could employ a physician to handle the needs of that particular location, is that correct?

Dr. LONG. It would be a group of physicians. This is for group practice, not solo, more than one.

Mr. PICKLE. My State doesn't permit that. How in Texas would we be able to participate in something like that? It is against our State law to practice by employment in this manner.

Dr. LONG. Mr. Pickle, if you are referring to the corporate practice of medicine—and that is what I think you are referring to—

Mr. PICKLE. Yes.

Dr. LONG. It is generally against State law—I don't know about all the States, but it is certainly generally true. Under the conditions

that you have suggested, this wouldn't be legal, as I understand it.

Mr. PICKLE. I don't think it would be legal in my State; and that is the reason I asked.

I thank you very much. That is all, Mr. Chairman.

The CHAIRMAN. Mr. Broyhill.

Mr. BROYHILL. No questions.

The CHAIRMAN. Mr. Murphy?

Mr. MURPHY. Dr. Long I certainly appreciate your statement. It has brought up some differences that haven't heretofore come before the committee.

Now, on page 12 of your statement you say: "We strongly urge that you reject H.R. 2987 as being unnecessary and unwarranted expenditure of public funds, and a discriminatory bill designed to give certain physicians an advantage not available to others." Last year in a debate on one of the medical training measures to come before the Congress, one of the problems in the country was having proper medical facilities, and not only facilities, but doctors in rural areas. And if these students would agree to a training contract and then to stay in the rural area, the Government would give them greater monetary assistance in their medical training. Does the AMA feel that this condition does not exist in the country?

Dr. LONG. No, sir. The AMA knows that there is a problem of distribution of physicians, that as our society has changed over the years from an agricultural to an urban society, that it is to suburban areas that doctors are most attracted, as are most all other people. It is difficult indeed to get physicians as well as other highly specialized people in other professions to go into rural areas, because they do not find either the educational, religious, cultural or other aspects of society that attracts them to communities.

Distribution is a real problem.

Mr. MURPHY. Don't you think that this legislation would make it easier and more attractive for doctors in rural areas to set up such facilities to practice?

Dr. LONG. No, sir, I do not. I believe it has been amply demonstrated—I have been sitting here all day, and Mr. Harvey made some comments a few minutes ago that certainly jibe with our part of the country. I am from Kentucky. When a doctor goes out into practice, he may not have a dime. Often he is many thousands of dollars in debt. But he has excellent credit. He is fortunate. There is something about the M.D. behind his name, about the training that he has had, and other things that make him fortunate in this respect. As far as I know, a physician of good moral character can go to a bank and say, "these are my plans, and these are my needs," and he can borrow money very easily. I don't think it has ever been demonstrated, sir, that you need a program such as this.

Mr. MURPHY. In New York several of the unions have set up complete clinics and, in effect, what they have done, the union funds have made available medical services which heretofore have not been made available at so cheap a fee, and people who probably would never have had opportunities to get medical care, can take advantage of this type of medical care in this union clinic.

Dr. LONG. I don't know that I have any comment to make there, sir, except that I am not quite sure how this relates to this bill, lending money to groups to build facilities, whether it be in rural or in large areas. Are you referring specifically to H.R. 2987?

Mr. MURPHY. No, I am saying that with a facility of this nature, say, supported by funding to set it up, that the fee scheduled charges in a group practice such as that would probably attract more people to use the medical facility.

Dr. LONG. I don't know about that, sir, but I would say that as far as financing such a facility, they could certainly do it through private means as well as through Government.

Dr. APPEL. Mr. Chairman, may I speak to Congressman Murphy's point?

The CHAIRMAN. Yes, Doctor.

Dr. APPEL. I would like to say, Congressman Murphy, that the American Medical Association does recognize that by the provision of adequate facilities we can attract doctors to areas where otherwise they would not go. We admit this, and we have evidence to prove this. It is not a question of getting loans elsewhere; they could get the loans, as Dr. Long has pointed out. But they are not just attracted to the area or the type of facilities that are there.

Because of our recognition of this fact, we have entered into a program with the Sears, Roebuck Foundation, which you may or may not know about. If I may, I would like to describe it to you as briefly as I can.

Under this program, the foundation, in conjunction with our medical advisory committee to the foundation, receives the requests of small rural communities who are desirous of having a doctor or another doctor. They may have one but feel they need two. This group employs personnel who are expert in evaluating the economic ability of a community to support a physician. This is important. A community may want a doctor, and it may be nice to have a doctor, but are there enough people there or enough need for a doctor to make a living? It may be better for the doctor to be, say, 10 miles away, where he could make a better living.

These employees of the Foundation go into the area and they evaluate the community on these points.

Then they advise the community, "Yes, you need a doctor, or you need two doctors. Now, this is how we feel you can get this money." And they organize the community to build the facility itself.

Through cooperation with our council on rural health of the American Medical Association, the Foundation brings physicians into the area, introduces them to the community. It arranges to have the community meet the doctor and the doctor meet the community.

There are some 30 communities, rural communities in the United States that have participated in this program in this way.

The facility that is thus built can be rented to the physician, or it can be amortized by the physician over a period of years so that he eventually owns it. We find this is a very good way to solve this particular problem. It is successful and it is successful throughout the country. This is one more reason why we question why the Government should come in to do this particular job when the communities themselves can do it and have proven they can do it.

Dr. LONG. Mr. Chairman, in this regard, sir, many, if not most of the State medical associations have a program under which a man who is qualified for medical school and who needs help in financing his way through medical school will make an agreement with the State medical society. His way will be paid through medical school, and 1, 2 or 3

years of graduate training, internship, and he will pay this back, not in dollars, but by going to a rural area in that State where a doctor or doctors are needed and pay it back on the basis of a year for a year.

This is another way in which we are trying to overcome this problem of the distribution of physicians, especially the shortage of physicians in rural communities.

Mr. MURPHY. No other questions, Mr. Chairman.

The CHAIRMAN. Mr. Harvey?

Mr. HARVEY. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Gilligan?

Mr. GILLIGAN. Just one, Mr. Chairman.

Doctor, again on this bill 2987, does the AMA take the position that comprehensive group practice is something desirable and that it should be encouraged?

Dr. LONG. We have never taken a position on group practice. We have never said we are for or against it. Of course, there are many advantages on group practice. We have no objection to any type of group practice whether it be a small medium or large group practice.

Mr. GILLIGAN. The reason I asked the question, Doctor, is that in Dr. Dempsey's statement given to us, there are several paragraphs quoted from the President's statement on health. His health message to the Congress, in which he cites the growth of group practice as a desirable end to be achieved:

The initial capital requirements for group practice, and the funds are not now sufficiently available to stimulate the expansion and establishment of group practice, to facilitate and encourage this desirable trend, I recommend legislation, and so forth.

And then the statement of the Department concludes:

The bill under consideration is designed to carry out the President's recommendation.

In other words, they have set up a goal.

So, the President's advisers in preparing this message, apparently found difficulty in the field of financing these new facilities which you have not found.

And then I suppose it would be a question as to whether those difficulties really exist or not.

But it is not then a question on your part of the desirability of group practice. You do believe that this is and can be a good thing for America?

Dr. LONG. There is no question about that, Mr. Gilligan. The group practice has proven itself.

This doesn't mean on the other hand, sir, that this is necessarily a superior type of practice to solo practice. Some types of practice suit one person better than another. Some people can't work in groups, and some patients don't want to go to a group, they want to go to an individual. But I don't think anyone has been able to correlate—and we have made a study through our commission on the cost of medical care preferences as they relate to solo practice and group practice.

Mr. GILLIGAN. One further point. I might say that there are a great many physicians who are living in residences today who have FHA guaranteed mortgages. And I would assume that there would be no objection to working in a building that was thus financed rather than living in one.

Dr. LONG. Not at all, sir.

The CHAIRMAN. As a matter of fact, we had a similar issue 2 years ago and some suggestion has been made in the record here about the committee's striking it out, indicating it was turned down. I should think we would remember just what was the problem and what was the result. We got into a jurisdictional question with the Banking Committee which has jurisdiction over mortgage loans. And Mr. Albert Rains, who was here at that time, the chairman of the Subcommittee on Housing of that committee advised this committee officially that that committee would take it up, that there was interest in loans being extended in this field.

We passed the ball to the Banking Committee. There was a great deal of discussion within this committee at that time, as those of us here will recall, not that it was a bad thing at all but that it should not be a program set up under HEW which has no facilities to administer a program of this kind, but it should be under FHA, which is an experienced agency of the program.

And I think we should pursue this thought further.

And since you have mentioned it, Doctor, in your response to Mr. Gilligan a moment ago, do you think that the FHA program should be extended if it is necessary to extend it to cover such requests as are contained here? But like Mr. Gilligan, I do know that there are FHA homes with offices in the homes.

Mr. HARVEY. Will the gentleman yield just a minute?

The CHAIRMAN. Yes, indeed.

Mr. HARVEY. I served on the Housing Subcommittee of Banking and Currency also, and I think that the maximum they would go up to was \$25,000 house. And I don't think that there are too many physicians, at least not in Michigan, that are living in \$25,000 houses. They are much above that, and they have conventional loans for that reason. So I don't think that they could very well avail themselves of the FHA provision. But that was the reason for my question earlier. The President transmitted just yesterday a very lengthy housing message which was referred to the Housing Committee. And I wonder why it was not included in that particular message, because I thought it would have been very appropriate.

The CHAIRMAN. It was also included in the message which came over here, I suppose was the reason, and that is the reason we would want to explore it and talk to the people about it.

Mr. GILLIGAN. Might I just add one comment to that. We know from the field of urban and renewal and local government that FHA mortgages are extended now to cover only residential dwellings. And it may be that there is a certain reluctance on the part of the Housing and Home Financing Agency to open up FHA mortgages to any other than residences.

The CHAIRMAN. Two years ago it was not authorized. They couldn't do it. I haven't pursued it any further, however.

Dr. Carter has come in, Dr. Carter from Kentucky. And being a colleague of these three gentlemen at the table, as well as a member of this committee, we will give you an opportunity to ask them any questions you desire, Dr. Carter.

Mr. CARTER. Thank you. I want to thank the eminent members of the profession for stating their case so well. Certainly I welcome Kentuckians also, and one who happens to be Congressman Farnsley's constituent.

In going into bill 2987 just a little bit, in Kentucky it is true, I believe, that we have the rural scholarship plan to interest people to go into places back in the hills.

Dr. LONG. That is correct, sir.

Mr. CARTER. As a usual thing they haven't had much trouble in getting financing for their practices, is that true?

Dr. LONG. That is true. They have had no trouble in financing their practices.

Mr. CARTER. Have you heard of any medical practitioner who has not been able to build a clinic or office wherever he wanted to because of inability to get funds?

Dr. LONG. No, sir.

Mr. CARTER. Do you see any need, then, for this bill, 2987?

Dr. LONG. No, Dr. Carter. The association sees no need for this bill.

Mr. CARTER. There is another question about the better health bill. I think on the whole it is a very fine bill. But what percentage of the cost of the bill is involved in the cost of staffing? It seems to me that putting up these buildings involves a big amount, a huge sum of money is invested in the buildings and the ground that goes with them, and so on. But what percentage of that is required for staffing, say, for 1 year, of the total cost?

Dr. LONG. According to the provisions of the bill, as I understand them, if this bill became law, then a budget for staffing would be permitted and if it were approved it would mean, in the first year, 75 percent of this budget for staffing would be paid by Federal funds; that is, 15 months, the second year 60 percent, the third year 45 percent, and the fourth year 30 percent.

Mr. CARTER. As I understand it, the cost of the staff would not be great.

Dr. LONG. No; the greatest cost would be bricks and mortar.

Mr. CARTER. And in rich communities particularly, if they can afford these buildings—as some of our larger States can—they might as well provide the sites for them.

That is all. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Farnsley.

Mr. FARNSELEY. I appreciate it, Mr. Chairman.

I would like to ask my distinguished friend and constituent—and I can almost make you a constituent, Dr. Appel—my family went from Lancaster to Kentucky, although it was about 200 years ago. On page 11 at one point you say that if a community cannot or will not support the program from its beginning years, it is unlikely to do so later, and then later on down you say you don't think there is any inability. I would like to think that the most human profession that I know of, and the most generous of its time and skills, as you say the second time, does provide these things in some areas. I don't want to put any words in your mouth. Do you see what is worrying me? At the bottom you say there is no inability, and in the middle of the page you say even if they cannot, it should be local responsibility.

Dr. LONG. I think we are talking about two different things, Mr. Farnsley. If I understand correctly, in this sentence it says, if the communities cannot or will not support the program from its beginning years, it will not be likely to do so later. We are referring primarily to motivation. No community program is going to work if

people in that community do not want it to work and they do not have enough interest and motivation to see it work. This is the point of reference.

Down here we are talking about planning. The States are now planning for the construction. And so up in this paragraph we are talking about motivation for staffing, and down here planning on construction. And even though funds may not be currently available, the States in the planning stage are continuing, utilizing funds of their own.

Now, that is my interpretation of it, and I will see if my colleagues concur in it.

Mr. FARNSLEY. I understand that. Let's forget about the planning. I understand what you are saying.

On the question of staffing, do you all take the position that even if you were convinced the community could not do it, could not support it, you would be against it?

Dr. LONG. Our policy, sir, is that we are opposed to Federal funds for staffing.

Mr. FARNSLEY. Are you opposed to it even if you were convinced the community could not do it? Is that a fair question? Or do you want to write me later on it?

Dr. LONG. The question is perfectly fair, sir. It seems to me, sir, to be a matter of philosophy. As far as I can see what we are getting into, if a community wants something badly enough the community will find a means to finance it. That is the basic, philosophical position that we hold.

Would you comment on that, Dr. Howard?

Dr. HOWARD. May I make this additional comment. It seems to us that a community or State which finds the funds to help finance the heavy cost of building community mental health facilities probably can find the funds to staff these facilities. We don't think this is a logical conclusion for a State to argue, that it cannot provide any funds for staffing, and at the same time it does successfully provide funds for financing construction.

Mr. FARNSLEY. But if it cannot provide funds for financing construction, where do you stand if you were convinced that it could not, sir?

Dr. HOWARD. That is one of those "iffy" questions. The fact is that all the States are now in the process of planning for the development of these community mental health center programs.

Mr. FARNSLEY. You realize that you are in a respected organization, one which means a great deal to the people in this country and to me. And I have worked awfully hard to help finance medical schools and hospitals, and I believe in them. But I have also worked hard to learn political science. I went back to school for 2 years of graduate work and then to graduate degree. And I interned in the legislature, and as a mayor. Now, have you all consulted any tax people on this, any economists, anybody like that? I am not fussing, I am asking. I am your friend. I think you are out of your field in some of this.

Dr. APPEL. Let me take a crack at your question. I know exactly what you are referring to.

One of the basic things in the State plan is that the location of these community facilities should be very carefully considered. In planning

their location, I think that the aspect of support for the facility should be considered in determining whether they are going to put a facility in this location or in that location.

There is no great need that these locations should be 5 blocks apart or 10 miles apart. Transportation today throughout the United States is such that we can travel. It is just like in hospital planning in our efforts to increase the number of hospital beds in this country, that we find communities in this country utilizing Hill-Burton funds—which I endorse, you understand—with surplus beds. Of course, we have a lot of communities that do not have sufficient beds. So we have gone into regional planning of hospital beds, and we consider this economic aspect of where to locate hospitals and where to increase the number of beds. We should apply the same philosophy as locating community mental health centers.

It is conceivable, Mr. Farnsley—and I don't question this point—that there may be some large geographic area in the country whose economic status is such that it might need some help on the particular regard to which you are referring. But there are going to be so few of them that I, personally; think that the State itself and the surrounding communities can do the job.

Mr. FARNSLEY. In other words, when you say community support you include the State?

Dr. APPEL. Yes, sir.

Mr. FARNSLEY. Of course, the political scientist says that the major justification for overall taxation in a situation like this is that the State tax is because some counties can't afford. I would rather have the counties do it all.

Dr. APPEL. So would I.

Mr. FARNSLEY. And I think you would. But I depend on the State doing it, because then the poor counties can be taken care of.

Now, I depended during my campaign on the Federal Government taking care of poor States. Now, this, of course, is my mental philosophy. The things you say you are for, I think, are wonderful, in fact you go further than I do. But if you are convinced that the people couldn't really get—really the State couldn't afford it—I wish you would talk to some experts or at least talk to them in this field—I don't want to belabor the point, but you see my point and I see yours.

Mr. CARTER. Will the gentleman yield?

Mr. FARNSLEY. Yes, sir.

Mr. CARTER. I think I see your point, Mr. Farnsley, and I am in agreement with you. And I don't want to go on the record as being against the needs of a State or community which requires Federal aid.

Mr. FARNSLEY. Thank you, Doctor. I know how kindly the medical profession is, and how much they have given of their time. And I know that if you weren't convinced that a community shouldn't have the thing you say it needs that you would be against getting it by overall taxation.

Dr. LONG. Mr. Chairman, I am sorry to be so slow. I must apologize to my own congressman from my own district for being so slow.

Mr. Farnsley, it finally came through my thick head what you are talking about. It is obvious under the terms of your question, where there is a need, if it cannot be met in one manner it must be met in another manner. And if it cannot be met on the local level or the

county or State level, then obviously if that need can be met on the Federal level, it must be met on the Federal level.

Does that answer it?

Mr. FARNSLEY. That answers it beautifully. And my respect for your profession is right back where it was 20 minutes ago.

Dr. LONG. Like all of you, I have been sitting here since 10 o'clock this morning. And I am a little slow on the uptake.

The CHAIRMAN. Mr. Callaway.

Mr. CALLAWAY. I would like to get back to H.R. 2987.

You made a statement about the distribution of doctors. And my own State of Georgia is quite typical of that. In some areas far from the cities the need for doctors is great. And Georgia is one of the States that participates on the State level in what you have done in your association in providing funds for loans for service in the rural communities. And I suspect that the problem is of getting the doctors rather than getting the housing for them and the mortgages. But in Georgia it seems to me that the need is really greatest, not in a city of even 10,000 or 15,000, but in communities with 1,000 or 2,000 people. And here we are talking about a single doctor operation. Now, in your understanding of this bill H.R. 2987, would a single doctor be eligible for this kind of mortgage, or is it just for groups?

Dr. LONG. It is just for groups.

Mr. CALLAWAY. Is there any possibility, in your judgment, that this bill, by making it easier for the doctor to go into a group in a larger community, might contribute to the distribution problem that we are trying to cure? Is this possible under this bill?

Dr. LONG. I think the point is well taken, sir, if I understand it. And that is, he may wish to go into a rural area, and find it much easier to join a group in another area without the problems that you have brought up.

Mr. CALLAWAY. My experience in Georgia has been that the need for single doctors is great, there is this same problem of distribution that you bring out. And it seems to me that this bill may hinder rather than help the solution of this problem.

Dr. LONG. Yes, I would agree to that.

Mr. CALLAWAY. Thank you, Mr. Chairman.

The CHAIRMAN. Any further questions?

Thank you very much, Doctors, each and every one of you, for your contribution to these hearings. We are glad to have your views collectively and individually on behalf of your organization. We are sorry we have detained you so long.

Dr. LONG. Thank you, Mr. Chairman. We enjoyed being here the whole day and listening to the other witnesses.

The CHAIRMAN. Dr. Lawrence Kerr.

STATEMENT OF DR. I. LAWRENCE KERR, COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION; ACCOMPANIED BY BERNARD J. CONWAY, CHIEF LEGAL OFFICER

Dr. KERR. I will, with your permission, omit possibly a couple of paragraphs.

The CHAIRMAN. Your entire statement will be included in the record, and you may emphasize such points as you desire.

(The complete prepared statement of Dr. Kerr is as follows:)

STATEMENT OF AMERICAN DENTAL ASSOCIATION ON H.R. 2984, H.R. 2986, AND H.R. 2987

Mr. Chairman and members of the committee, my name is Dr. I. Lawrence Kerr, of Endicott, N.Y. In addition to maintaining a private practice in that city, I am a member of the American Dental Association's Council on Legislation and am here today representing that organization. Accompanying me is Mr. Bernard J. Conway, chief legal officer of the American Dental Association. It is a distinct privilege, Mr. Chairman, to appear before this committee.

I will confine my comments to H.R. 2984, H.R. 2986, and H.R. 2987. The association has no position on H.R. 2985 which relates to community mental health centers.

Before referring specifically to the provisions of H.R. 2984, H.R. 2986, and H.R. 2987, I would like to comment briefly on the scope and seriousness of the dental disease problem in this country.

Dental diseases are the most prevalent of all chronic diseases; 97 million Americans suffer from tooth decay; 23 million have periodontal disease; 65,000 children under 18 have cleft lip or palate; 23,000 people develop oral cancer annually; and more than half of our people over the age of 55 are without natural teeth.

Personal dental health services cost about \$2.4 billion annually, about one-sixth of the amount spent for all health services. Due to oral disease, some 85 million man-hours of industrial production are lost each year.

Every 100 inductees into the military service require, on the average, 505 fillings, 80 extractions, 25 bridges, and 20 dentures.

Only 40 percent of the people of this Nation receive dental treatment each year. Among children aged 5 to 14, nearly 42 percent from rural farms have never been to a dentist; 23 percent of the children from urban areas have never been to a dentist. Almost 60 percent of the children aged 5 to 14 years in families with annual incomes of under \$2,000 have never been to a dentist.

Programs authorized under both H.R. 2984 and H.R. 2986 can make sizable contributions to the effort to control and prevent dental disease. H.R. 2986 deals among other things with support for State and local dental public health measures and H.R. 2984 with the facilities for conducting health research, including dental research. H.R. 2987 authorizes loans and loan guarantees for the construction and equipping of facilities for medical and dental group practice.

With respect to H.R. 2986, we will restrict our comment to the provision for a 1-year extension of section 314(c) of the Public Health Service Act which is due to expire at the end of fiscal 1966. Section 314(c) is of particular concern to us because it authorizes the grant-in-aid program to assist State and local dental public health units that was initiated in the current fiscal year. We support this extension and would like to suggest some opportunities this "year of grace" presents to the Federal Government.

Before discussing them in detail, however, we should like to direct your attention to H.R. 2984.

H.R. 2984

The American Dental Association is most sympathetic to the purposes of H.R. 2984. The two points in the bill which are of special importance are those that (1) increase the ceiling under the Health Research Facilities Act from \$50 million a year to a 5-year total of \$400 million, and (2) authorize a program to encourage the development of regional research centers devoted to specific major diseases.

Our major interest, quite naturally, is to judge what effect these changes will have on the future of dental research in this country. Our strong conviction is that both of them will have a beneficial and vitalizing effect and that some aspects of them are essential to further development of dental research.

For some time it has been apparent that there were more projects worthy of support under the Health Research Facilities Act than could be accommodated by the \$50 million ceiling. For several years there has been a backlog of applications that were approved but could not be funded. This has been compounded recently by the activity under the Health Professions Educational Assistance Act passed in 1963 and fully operative for the first time during this current fiscal year. As was the intent of the act, it has greatly stimulated the renovation and expansion of existing schools and the planning of new teaching facilities where local opinion deemed it necessary.

In dentistry thus far, nine dental schools have received funds under this act. In addition, 12 other applications are in one stage or another of consideration. Another 21 schools have given indication of their intention to request support

in the relatively near future. According to present information at least five and perhaps seven new dental schools are in the planning stage.

These are notable achievements and will pay real dividends in the future in terms of better health care for the American people. Everyone who worked for passage of the Health Professions Educational Assistance Act can take pride in this rapid implementation.

This burgeoning activity in the construction of dental teaching facilities, however, has highlighted an accompanying and urgent need for additional research facilities money. No one needs to be an expert either in planning or in health education to recognize that it makes no sense at all to build a new school or enlarge an existing one without making adequate provision for research facilities that are built into the very structure of the institution. In this day and age, there is no need to defend research or explain its necessity; it is the foundation stone of all progress. Without a substantial increase in the ceiling of the Health Research Facilities Act, we will be faced with the prospect of expanding some schools in a less than fully useful way or of building new schools that are less than complete when they open their doors. This should not be allowed to happen. It would have a deleterious effect on the quality of education provided to students, would retard progress in research and in the long run would be extremely uneconomical since research facilities must, at some time, be built.

H.R. 2984 proposes an increase in the ceiling from \$50 to \$400 million over the next 5 years. The association believes this would be of material benefit to the health field. At the same time we believe that this average figure of \$80 is realistic if we are to continue to progress in this vital area as quickly as we could and should.

There is, as well, an amendment which we think the committee should consider and adopt. This would be to grant discretionary authority to the administrators of the Health Research Facilities Act to raise the Federal matching share at least to the level allowed in the Health Professions Educational Assistance Act, which is 66.7 percent, and preferably to the 75 percent recommended by the President's Commission on Heart Disease, Cancer, and Stroke.

One of the major benefits of increasing the allowable Federal share would be to assist schools that are not now able to realize their full research potential. Some schools have in the past, for any number of reasons, been able to mount excellent research programs. Once begun, they have been able to build their programs consistently with their own resources and the continuing help of the Federal Government. Not all schools, however, have been so fortunate. Others, though they possess or can acquire the academic and intellectual capability, could not make a real beginning because of lack of facilities. Certainly, no one wants to forever preclude such institutions from beginning to build the outstanding research programs of which they are capable. Under present law, however, we are running the risk of doing so. The change in the matching formula that we recommend would go a long way toward alleviating and remedying this situation.

Addressing itself to this problem, the report of the President's Commission on Heart Disease, Cancer, and Stroke has this to say: "The present 50 percent ceiling works a most severe hardship on those institutions in less economically favored parts of the country, which cannot compete in raising matching moneys with the large, established research complexes. Yet these smaller and financially weaker research institutions are the very ones we must strengthen if we are to achieve a truly broad, regional expansion of our research effort. There is also a lack of nonmatching authority for the construction of research facilities that are national or regional in their scope."¹

In making this suggestion, Mr. Chairman, we should like to emphasize that in our opinion the increased Federal percentage need not be across the board but would be granted only in selected circumstances. We would estimate that the overall average of Federal participation would remain at approximately 50 percent.

There is one more major provision of H.R. 2984 that we should like to comment on. This is the authorization of the program to encourage the development of research institutes of national and regional significance. The establishment of precisely just such institutes has been a matter of discussion not only in dentistry but also before the Appropriations Committees of Congress.

It has been gratifying to note the number of adherents this idea has gained in the past few years. Among them is Dr. James A. Shannon, director of the Na-

¹ The President's Commission on Heart Disease, Cancer and Stroke: Report to the President on a national program to conquer heart disease, cancer and stroke, December 1964, vol. 1, p. 72.

tional Institutes of Health, who, in referring to such dental research institutes, said: "It is my personal conviction . . . that it is this type of approach that will break the mold of the past, broaden research in the dental sciences and provide adequate training spots for true scientists within the profession. I think this approach would have a profound impact on dental research activities in as little as 5 years."²

Such centers as we are discussing would be somewhat similar to the National Institute of Dental Research. The staff would consist not only of dentists or dentists with additional doctorates but also students of all those disciplines we now know to be relevant to dental research such as biochemistry, pharmacology, crystallography, radiology and so forth.

In this way, a large and varied number of high-caliber scientists can be attracted to a career in dentally oriented research. This approach also would make it more certain than ever that dental research would progress in a meaningful unified fashion and not risk isolated, fragmented development. Great progress could thus be made in controlling and preventing the country's most prevalent disease.

The National Institutes of Health has done more than merely agree that this concept is viable. In late 1964, an advisory committee composed of some of the country's leading scientists was appointed by Dr. Shannon to study and discuss the feasibility of establishing dental research institutes. This committee, we understand, has all but completed its deliberations and the American Dental Association has every expectation that its report will reflect acceptance and strong support for this concept.

The association believes such oral research institutes to be precisely the kind of centers envisioned by the President in his health message and by the framers of H.R. 2984. The adoption of this proposal would be a giant step toward implementation of this concept and for this reason, we strongly urge passage of this portion of the bill.

Finally, we should like to voice our support for section 4 of H.R. 2984 which would create three new Assistant Secretaries for the Department of Health, Education, and Welfare. We are particularly gratified to note the desirable upgrading of the position of Special Assistant to the Secretary (Health and Medical Affairs) to the level of an Assistant Secretary. At the same time, we should like to make clear our conviction that this important post should always be occupied either by a member of the health professions or by one such as the present incumbent who is intimately conversant with health matters.

H.R. 2986

We would like now to comment very briefly on that section of H.R. 2986 that would extend the authority under section 314(c) of the Public Health Service Act until June 30, 1967.

As we understand it, this is in accordance with the request of President Johnson who, in his recent health message, said: "I have directed the Secretary of Health, Education, and Welfare to study these programs thoroughly and to recommend to me necessary legislation to increase their usefulness. Authorizations for many of these programs expire at the close of fiscal year 1966. So that a thorough review may be made, I recommend that the Congress extend the authorizations through June 30, 1967."

We agree that a review may be in order, but we also believe that during this suggested review period a good deal more could be done under the existing authority of section 314(c). This is particularly true with respect to the program of grants-in-aid to assist dental public health programs at State and community levels. During the last Congress the distinguished chairman of this committee introduced legislation on this very point. The purpose of this legislation was accomplished, at least in principle, through the appropriations process under the authority of section 314(c) of the Public Health Service Act. For this year, the amount authorized is \$520,000 or about \$10,000 per State. It is recognized that this is "starter" money and we are grateful for it. In all candor, however, it must be admitted that such a sum is relatively insignificant when put next to the demonstrated need.

It is most disappointing to note that the fiscal 1966 budget provides no increase for this program, particularly in view of the strong support publicly given by the Department of Health, Education, and Welfare. Testifying before a Senate

² Department of Labor and Health, Education, and Welfare appropriations for 1964, hearings before a subcommittee of the Committee on Appropriations for 1964, Department of Health, Education, and Welfare, pt. 3, National Institutes of Health, pp. 589-590.

come, mattei representative of the Department stated: "In our opinion, the need for increased attention to dental public health activities clearly justifies the initiation at this time of an earmarked grant for this purpose."³

What was said then is true today. The problem grows increasingly serious and remedial action could be taken now. We hope Congress will give this matter its attention.

In the meantime, we support the 1-year extension of section 314(c) since we have every expectation that the Department of Health, Education, and Welfare will make fruitful use of the extra year to make the "thorough review" requested by the President. We are confident the Department will give the needs of dental public health the attention they deserve and that its ultimate recommendation will reflect the favorable position it has previously taken.

H.R. 2987

H.R. 2987 proposes a mortgage insurance and loan plan to assist in constructing group practice dental and medical facilities. The American Dental Association believes that enactment of H.R. 2987 is unnecessary and might even be a deterrent to the expansion of high quality dental and medical practice in the United States.

There are two distinct categories of group practice facilities treated in H.R. 2987. One is a facility owned by a medical or dental practice team organized by the professional practitioners themselves to provide care on a fee for service basis in the same way the physician or dentist in individual private practice offers his services to the public. The second category of group practice facility is, typically, established by a group of nonprofessionals for the purpose of providing care to subscribers or to members of the establishing group. The lay group, organized as a consumer cooperative or nonprofit prepayment plan, hires physicians or dentists or both on a salary basis. The health profession associations refer to this second category of group practice facility as a closed panel practice or clinic.

The association has both professional and pragmatic objections to H.R. 2987. The bill is designed to encourage professional practitioners in dentistry and medicine to establish facilities for large, comprehensive group practices. The American Dental Association does not believe the Federal Government should, as a matter of public policy, prefer one mode of professional practice over such other traditional and efficient modes as small partnerships and individual practices.

Additionally, H.R. 2987, by giving priority to group practice facilities owned by "cooperatives or other nonprofit organizations" is in the association's opinion designed primarily to spur the establishment of nonprofessionally owned and controlled closed panel practices. It is the association's conviction that the proliferation of such facilities would tend to lower the quality of health care in the Nation.

Beyond the foregoing professional reasons, the association does not believe the approach taken in H.R. 2987 is practical or necessary.

As far as dental practice is concerned, there is no evidence of lack of loan resources for constructing professionally owned and managed dental practice facilities, including group practice facilities. Loans from private lending institutions, in the opinion of the association, are available to take care of most of the practice facility needs of the dental profession. Where private sources are not available at suitable interest rates, the dentist and physician, singly or in groups, can, like any other small business owner, apply to the Small Business Administration for assistance.

The Small Business Administration, in the association's opinion, is performing an exceptional service in providing loan resources for dentists and physicians where private lenders alone are unable to do so. The association is convinced that H.R. 2987 would not only duplicate the very effective program of Small Business Administration loans for dentists and physicians, but the creation of the new program in H.R. 2987 might eliminate dentists and physicians from access to the Small Business Administration program. (The law under which the Small Business Administration loan program is administered specifies that Small Business Administration loans will not be available to persons or entities which are eligible for some other Federal loan program.) The American Dental Association believes that any objective study of the resources available for construction of medical and dental practice facilities will reveal no need for additional Federal loan support at this time.

³ Control of Dental Diseases, hearing before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, 87th Cong., 2d sess., on S. 917, May 24, 1962, pp. 3-16.

Even if it could be shown that some few types of practices are not able to obtain adequate financing, the most likely and practical remedy that should be explored is through amendment of the existing Small Business Administration program.

Finally, the association does not believe that the 5 percent loans in H.R. 2987 will induce dentists and physicians to locate in "smaller communities of the Nation." It is our opinion that many other factors are far more important. We believe, for example, that the Department could make a much greater contribution by supporting the association's proposal to increase grants-in-aid to local and State dental public programs so that mobile dental units could be purchased and other similar measures taken to bring dental care to people in sparsely populated areas.

These then are the professional and pragmatic objections to H.R. 2987. In closing, I would like to stress our unreserved opposition to that part of H.R. 2987 which gives preference to practice facilities owned by consumer cooperatives and other non-profit organizations.

The American Dental Association has declared in several policy statements that professionally owned and managed private practice facilities, whether on an individual or group basis, are better suited to provide high quality health care than practices controlled by nonprofessional groups. The intrusion of lay ownership and control over a dental or medical practice may readily interfere with professional judgments and decisions to the detriment of patients who are being served.

The American Dental Association recommends that the committee disapprove H.R. 2987.

POLICY STATEMENTS ON NONPROFESSIONALLY OWNED OR CONTROLLED PRACTICES

1. The American Dental Association recognizes the propriety of providing group dental care as a benefit of employment, provided that the methods of financing and administering such programs are in keeping with the policies and principles of the association.

The association encourages the development of acceptable group dental care programs with participation by dentists in private practice rather than the establishment of facilities by or for the group and the use of salaried dentists * * *.

(Adopted by the house of delegates of the American Dental Association at its 1959 annual session. Trans. 1959:46.)

2. A closed panel practice is established when patients are obtained through the provisions of an agreement with a given group and when such agreement does not provide for the purchase of dental care by the patients from any other source.

Because of the essential limitation which this method of practice imposes on the patient, it should be discouraged. Closed panel practices should be established only in special circumstances to meet needs which cannot be met in any other way. When established, closed panel practices should be under the direct supervision of a dentist legally licensed in the State, should conform to the principles of ethics of the American Dental Association and the local codes of ethics and should maintain close liaison with the constituent and component dental societies of the area.

(Adopted by the house of delegates of the American Dental Association at its 1961 annual session. Trans. 1961:254.)

3. *Resolved*, That the council on legislation be directed to testify on proposed Federal legislation in connection with Federal mortgage loan insurance for health facilities that (1) the Federal Government should not stimulate the construction of additional dental treatment facilities within any community unless it can be shown that existing dental facilities are not adequate, and that (2) before establishing any Federal program designed to increase the number of dental treatment facilities, Congress should require that existing community facilities be surveyed according to a plan similar to that required under the present Hospital Survey and Construction Act.

(Adopted by the house of delegates of the American Dental Association at its 1955 annual session. Trans. 1955:215.)

Dr. KERR. Mr. Chairman and members of the committee, my name is Dr. I. Lawrence Kerr of Endicott, N.Y. In addition to maintaining a private practice in that city, I am a member of the American Dental Association's Council on Legislation and am here today representing

that organization. Accompanying me is Mr. Bernard J. Conway, chief legal officer of the American Dental Association. It is a distinct privilege, Mr. Chairman, to appear before this committee.

I will confine my comments to H.R. 2984, H.R. 2986, and H.R. 2987. The association has no position on H.R. 2985 which relates to community mental health centers.

In my prepared statement, Mr. Chairman, which I respectfully request be placed in the record, I comment on the scope and seriousness of the dental disease problem in this country. In order to conserve the committee's time, I will omit this from my oral testimony.

With respect to H.R. 2986, we will restrict our comment to the provision for a 1-year extension of section 314(c) of the Public Health Service Act which is due to expire at the end of fiscal 1966. Section 314(c) is of particular concern to us because it authorizes the grant-in-aid program to assist State and local dental public health units that was initiated in the current fiscal year. We support this extension and would like to suggest some opportunities this "year of grace" presents to the Federal Government.

Before discussing them in detail, however, we should like to direct your attention to H.R. 2984.

The American Dental Association is most sympathetic to the purposes of H.R. 2984. The two points in the bill which are of special importance are those that (1) increase the ceiling under the Health Research Facilities Act from \$50 million a year to a 5-year total of \$400 million, and (2) authorize a program to encourage the development of regional research centers devoted to specific major diseases.

Our prime interest, quite naturally, is to judge what effect these changes will have on the future of dental research in this country. Our strong conviction is that both of them will have a beneficial and vitalizing effect and that some aspects of them are essential to further development of dental research.

For some time it has been apparent that there were more projects worthy of support under the Health Research Facilities Act than could be accommodated by the \$50 million ceiling. For several years there has been a backlog of applications that were approved but could not be funded. This has been compounded recently by the activity under the Health Professions Educational Assistance Act passed in 1963 and fully operative for the first time during this current fiscal year. As was the intent of the act, it has greatly stimulated the renovation and expansion of existing schools and the planning of new teaching facilities where local opinion deemed it necessary.

In dentistry thus far nine dental schools have received funds under this act. In addition, 12 other applications are in one stage or another of consideration. Another 21 schools have given indication of their intention to request support in the relatively near future. According to present information at least five and perhaps seven new dental schools are in the planning stage.

These are notable achievements and will pay real dividends in the future in terms of better health care for the American people. Everyone who worked for passage of the Health Professions Educational Assistance Act can take pride in this rapid implementation.

This burgeoning activity in the construction of dental teaching facilities, however, has highlighted an accompanying and urgent need for additional research facilities money. No one needs to be an

expert either in planning or in health education to recognize that it makes no sense at all to build a new school or enlarge an existing one without making adequate provision for research facilities that are built into the very structure of the institution. In this day and age, there is no need to defend research or explain its necessity; it is the foundation stone of all progress. Without a substantial increase in the ceiling of the Health Research Facilities Act, we will be faced with the prospect of expanding some schools in a less than fully useful way or of building new schools that are less than complete when they open their doors. This should not be allowed to happen. It would have a deleterious effect on the quality of education provided to students, would retard progress in research and in the long run would be extremely uneconomical since research facilities must, at some time, be built.

There is, as well, an amendment which we think the committee should consider and adopt. This would be to grant discretionary authority to the administrators of the Health Research Facilities Act to raise the Federal matching share at least to the level allowed in the Health Professions Educational Assistance Act, which is 66.7 percent, and preferably to the 75 percent recommended by the President's Commission on Heart Disease, Cancer, and Stroke.

One of the major benefits of increasing the allowable Federal share would be to assist schools that are not now able to realize their full research potential. Some schools have in the past, for any number of reasons, been able to mount excellent research programs. Once begun, they have been able to build their programs consistently with their own resources and the continuing help of the Federal Government. Not all schools, however, have been so fortunate. Others, though they possess or can acquire the academic and intellectual capability, could not make a real beginning because of lack of facilities. Certainly, no one wants to forever preclude such institutions from beginning to build the outstanding research programs of which they are capable. Under present law, however, we are running the risk of doing so. The change in the matching formula that we recommend would go a long way toward alleviating and remedying this situation.

Addressing itself to this problem, the report of the President's Commission on Heart Disease, Cancer, and Stroke has this to say:

The present 50-percent ceiling * * * works a most severe hardship on those institutions in less economically favored parts of the country, which cannot compete in raising matching moneys with the large, established research complexes. Yet these smaller and financially weaker research institutions are the very ones we must strengthen if we are to achieve a truly broad, regional expansion of our research effort. There is also a lack of nonmatching authority for the construction of research facilities that are national or regional in their scope.

In making this suggestion, Mr. Chairman, we should like to emphasize that in our opinion the increased Federal percentage need not be across the board but would be granted only in selected circumstances. We would estimate that the overall average of Federal participation would remain at approximately 50 percent.

There is one more major provision of H.R. 2984 that we should like to comment on. This is the authorization of the program to encourage the development of research institutes of national and regional significance. Discussion of just such institutes has not been restricted to dental circles but has been considered by various institutions of higher

learning, the National Institutes of Health and Appropriations Committees of Congress.

It has been gratifying to note the number of adherents this idea has gained in the past few years. Among them is Dr. James A. Shannon, Director of the National Institutes of Health, who, in referring to such dental research institutes, said:

It is my personal conviction * * * that it is this type of approach that will break the mold of the past, broaden research in the dental sciences and provide adequate training spots for true scientists within the profession. I think this approach would have a profound impact on dental research activities in as little as 5 years.

The National Institutes of Health has done more than merely agree that this concept is viable. In late 1964, an advisory committee composed of some of the country's leading scientists was appointed by Dr. Shannon to study and discuss the feasibility of establishing dental research institutes. This committee, we understand, has all but completed its deliberations and the American Dental Association has every expectation that its report will reflect acceptance and strong support for this concept.

The association believes such oral research institutes to be precisely the kind of centers envisioned by the President in his health message and by the framers of H.R. 2984. The adoption of this proposal would be a giant step toward implementation of this concept and for this reason, we strongly urge passage of this portion of the bill.

Finally, we should like to voice our support for section 4 of H.R. 2984 which would create three new Assistant Secretaries for the Department of Health, Education, and Welfare. We are particularly gratified to note the desirable upgrading of the position of Special Assistant to the Secretary (Health and Medical Affairs) to the level of an Assistant Secretary. At the same time, we should like to make clear our conviction that this important post should always be occupied either by a member of the health professions or by one, such as the present incumbent, who is intimately conversant with health matters.

H.R. 2986

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As we understand it, this is in accordance with the request of President Johnson who, in his recent health message, said:

I have directed the Secretary of Health, Education, and Welfare to study these programs thoroughly and to recommend to me necessary legislation to increase their usefulness. Authorizations for many of these programs expire at the close of fiscal year 1966. So that a thorough review may be made, I recommend that the Congress extend the authorizations through June 30, 1967.

We agree that a review may be in order, but we also believe that during this suggested review period a good deal more could be done under the existing authority of section 314(c). This is particularly true with respect to the program of grants-in-aid to assist dental public health programs at State and community levels. During the last Congress the distinguished chairman of this committee introduced legislation on this very point. The purpose of this legislation was accomplished, at least in principle, through the appropriations process under the authority of section 314(c) of the Public Health Service

Act. For this year, the amount authorized is \$520,000 or about \$10,000 per State. It is recognized that this is "starter" money and we are grateful for it. In all candor, however, it must be admitted that such a sum is relatively insignificant when put next to the demonstrated need.

It is most disappointing to note that the fiscal 1966 budget provides no increase for this program, particularly in view of the strong support publicly given by the Department of Health, Education, and Welfare. Testifying before a Senate committee, a representative of the Department stated:

In our opinion, the need for increased attention to dental public health activities clearly justifies the initiation at this time of an earmarked grant for this purpose.

What was said then is true today. The problem grows increasingly serious, and remedial action could be taken now. We hope Congress will give this matter its attention.

In the meantime, we support the 1-year extension of section 314(c) since we have every expectation that the Department of Health, Education, and Welfare will make fruitful use of the extra year to make the "thorough review" requested by the President. We are confident the Department will give the needs of dental public health the attention they deserve and that its ultimate recommendation will reflect the favorable position it has previously taken.

H.R. 2987

H.R. 2987 proposed a mortgage insurance and loan plan to assist in constructing group practice dental and medical facilities. The American Dental Association believes that enactment of H.R. 2987 is unnecessary and might even be a deterrent to the expansion of high quality dental and medical practice in the United States.

There are two distinct categories of group practice facilities treated in H.R. 2987. One is a facility owned by a medical or dental practice team organized by the professional practitioners themselves to provide care on a fee-for-service basis in the same way the physician or dentist in individual private practice offers his services to the public. The second category of group practice facility is, typically, established by a group of nonprofessionals for the purpose of providing care to subscribers or to members of the establishing group. The lay group, organized as a consumer cooperative or nonprofit prepayment plan, hires physicians or dentists or both on a salary basis. The health profession associations refer to this second category of group practice facilities as a closed panel practice or clinic.

The association has both professional and pragmatic objections to H.R. 2987. The bill is designed to encourage professional practitioners in dentistry and medicine to establish facilities for large, comprehensive group practices. The American Dental Association does not believe the Federal Government should, as a matter of public policy, prefer this one mode of professional practice over such other traditional and efficient modes as small partnerships and individual practices.

Additionally, H.R. 2987, by giving priority to group practice facilities owned by "cooperatives or other nonprofit organizations" is in the association's opinion designed primarily to spur the establishment of nonprofessionally owned and controlled closed panel practices.

It is the association's conviction that the proliferation of such facilities would tend to lower the quality of health care in the Nation.

Beyond the foregoing professional reasons, the association does not believe the approach taken in H.R. 2987 is practical or necessary.

As far as dental practice is concerned, there is no evidence of lack of loan resources for constructing professionally owned and managed dental practice facilities, including group practice facilities. Loans from private lending institutions, in the opinion of the association, are available to take care of most of the practice facility needs of the dental profession. Where private sources are not available at suitable interest rates, the dentist and physician, singly or in groups, can, like any other small business owner, apply to the Small Business Administration for assistance.

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Even if it could be shown that some few types of practices are not able to obtain adequate financing, the most likely and practical remedy that should be explored is through amendment of the existing Small Business Administration program.

Finally, the association does not believe that the 5 percent loans in H.R. 2987 will induce dentists and physicians to locate in "smaller communities of the Nation." It is our opinion that many other factors are far more important. We believe, for example, that the Department could make a much greater contribution by supporting the association's proposal to increase grants-in-aid to local and State dental public health programs so that mobile dental units could be purchased and other similar measures taken to bring dental care to people in sparsely populated areas.

These then are the professional and pragmatic objections to H.R. 2987. In closing, I would like again to stress our unreserved opposition to that part of H.R. 2987 which gives preference to practice facilities owned by consumer cooperatives and other nonprofit organizations.

The American Dental Association has declared in several policy statements that professionally owned and managed private practice facilities, whether on an individual or group basis, are better suited to high quality health care than practices controlled by nonprofessional groups. The intrusion of lay ownership and control over a dental or medical practice may readily interfere with professional judgments and decisions to the detriment of patients who are being served.

The American Dental Association recommends that the committee disapprove H.R. 2987.

Mr. Chairman, the association is grateful for this opportunity to present its views on these important matters. I will be glad to try and answer any questions that you or members of the committee may have.

The CHAIRMAN. Thank you very much, Dr. Kerr.

I observe you have an appendix to your statement. I assume you would like to have that included. It appears to be a policy statement.

Dr. KERR. Yes, sir; that and any of the other paragraphs that I did not include in my earlier testimony.

The CHAIRMAN. That has already been granted. And this appendix may be included with your statement.

And I do want to thank you for your statement.

We are glad to have Mr. Conway with us.

We appreciate the views of the American Dental Association, and we are glad to have their suggestions and recommendations.

Any questions?

Mr. Pickle?

Mr. PICKLE. No questions.

The CHAIRMAN. Dr. Carter?

Mr. CARTER. No questions.

The CHAIRMAN. Mr. Gilligan?

Mr. GILLIGAN. No, sir.

The CHAIRMAN. Mr. Farnsley?

Mr. FARNSLEY. I am grateful for a good statement.

The CHAIRMAN. On behalf of the committee let me thank you for your patience in remaining with us in order to make this record. And we apologize for keeping you so late.

Dr. KERR. We appreciate the opportunity of appearing before your fine committee.

The CHAIRMAN. Dr. Robert H. Felix is our next witness.

Dr. Felix, you have been very patient with us today. We know that you have gone to a lot of trouble to come from St. Louis, where you are busily engaged in St. Louis University as dean of the medical school. We are sorry that we detained you this long.

STATEMENT OF ROBERT H. FELIX, M.D., DEAN, ST. LOUIS UNIVERSITY SCHOOL OF MEDICINE, AND SECOND VICE PRESIDENT, NATIONAL ASSOCIATION FOR MENTAL HEALTH

Dr. FELIX. Mr. Chairman, I have been before this committee a few times before.

The CHAIRMAN. We welcome you back.

Dr. FELIX. And I am glad to be back with you again.

Mr. Chairman, before I begin my testimony, I would like to file for the record the statement of Charles H. Frazier, my colleague in the National Association for Mental Health. Mr. Frazier was called away. His daughter, who is in the Peace Corps, was in one of the countries in Africa and was found to have something which required surgery, and they have brought her back. He had to get away to meet her. So I told him that if you would permit, I would just file his statement for the record.

The CHAIRMAN. Mr. Charles H. Frazier, of the National Association for Mental Health in Philadelphia?

Dr. FELIX. Yes, sir.

The CHAIRMAN. His statement may go into the record following your presentation here today. And we are very sorry to learn the reason he was suddenly called away. And we are sorry he could not appear personally.

Dr. FELIX. Thank you, sir. I know that he will appreciate your expression of sympathy.

I will contract my statement some because of the lateness of the hour.

The CHAIRMAN. Your entire statement will be included in the record.

(The complete prepared statement of Dr. Felix is as follows:)

TESTIMONY OF ROBERT H. FELIX, M.D., DEAN, ST. LOUIS UNIVERSITY SCHOOL OF MEDICINE, SECOND VICE PRESIDENT, NATIONAL ASSOCIATION FOR MENTAL HEALTH, ON H.R. 2985

My name is Robert H. Felix. I am a psychiatrist. I served as Director of the National Institute of Mental Health from its inception in 1949 until mid-1964. I am a past president of the American Psychiatric Association. My present position is dean of the School of Medicine at St. Louis University, St. Louis, Mo.

As a volunteer I serve as second vice president of the National Association for Mental Health and today I appear on behalf of that organization to testify in favor of the passage of H.R. 2985.

The National Association for Mental Health, with national headquarters at 10 Columbus Circle, New York City, is a citizens' organization having State divisions in nearly every State of the Union and chapters in more than 800 local communities. Its predecessor organization, the National Committee for Mental Hygiene, was organized in 1909. For more than 50 years the organization has given nongovernmental leadership to the fight against mental illness and to the promotion of mental health. It pioneered in the establishment of child guidance clinics and the training of professional personnel in the mental health field. It initiated inspection of mental hospitals. Directly and through its State divisions and local chapters, the NAMH conducts programs of service to the mentally ill and their families, education of the public, the police, the clergy, and teachers about mental illness and mental health, and a program of research into the causes and treatment of mental illness.

In my years as Director of the National Institute of Mental Health, I had many occasions to collaborate with the National Association for Mental Health. I found their lay and professional leaders competent and dedicated. The association was a valuable ally in our efforts at the Federal level to support research, training, and demonstration in the mental health field. I now serve not only as a vice president of the NAMH but I am also a member of its professional advisory council. My colleagues on the council include some of the most respected professional mental health leaders in the country.

The NAMH strongly endorses H.R. 2985. In our opinion passage of this measure and its companion piece in the Senate, S. 513, will complete the first essential steps in the "bold new program" requested by President Kennedy in his historic message to the Congress on mental health and mental retardation on February 5, 1963. I had much to do with the framing of those recommendations and I know that the staffing recommendations were regarded as equally important as the construction recommendations. As you know, the construction funds were authorized in Public Law 88-164 but the staffing provisions were not adopted. As President Johnson recommended in his health message of January 7, 1965, the time has come to authorize Federal funds to assist in meeting the initial costs of personnel for community mental health centers.

Both from my long experience in the NIMH and my few months as dean of a medical school, I know how important it is to provide professionally competent personnel for the new comprehensive community attack on mental illness. The NIMH training program which the Congress has consistently supported is based on the principle that better care of the mentally ill, in institutions and in the community, depends upon the availability of more and properly trained professionals—psychiatrists, nonpsychiatric physicians, psychologists, nurses, and social workers. Although we are still short of the total numbers needed, significant progress has been made.

The 1962 NIMH report to the Congress showed that in the decade from 1950 to 1960 the number of persons with recognized graduate training in the four basic mental health disciplines—psychiatry, clinical psychology, psychiatric social work and psychiatric nursing—rose from 12,000 to 44,000, an increase of 350 percent.

The 1964 NIMH training report to the Congress noted that the annual number of NIMH training stipends had risen to 7,000. In 1948, the number was 219.

In 1958 the Congress authorized the beginnings of a broad general practitioner training program in psychiatry. In the first year of the program, fiscal 1959, only 94 nonpsychiatric physicians were enrolled in the 3-year residency program. In the current year, more than 500 physicians are in residency training courses which will lead to their certification as psychiatrists.

Under this same program, its second part, more than 15,000 physicians have been enabled to take postgraduate courses in psychiatry.

This represents real progress in meeting the manpower problem in mental health.

In recent months in my new role, a medical school dean, I have become increasingly aware of the growing interest in mental health among medical students. I note increasing numbers of students who wish to explore the possibilities for careers in psychiatry. The current manpower problem is serious but it is certainly anything but hopeless—especially as new efforts are being made by the American Medical Association, the American Psychiatric Association and the NIMH to help nonpsychiatric physicians carry a greater part of the care of the mentally ill.

It was my great good fortune to have been head of the NIMH as the concept of community care of the mentally ill evolved. New methods of short-term intensive treatment made it possible to challenge the traditional procedure of sending the mentally ill away to large distant State institutions. They rendered archaic the concept of the mentally ill as the "wards of the State" who must be maintained for long periods of time at State expense in isolated mental hospitals. The new drugs and other treatment methods made it possible to conceive of treating the mentally ill on much the same basis as we treat the physically ill—to move the care of the mentally ill back into the mainstream of medicine.

These developments opened up a whole new range of challenging and exciting possibilities. We could foresee—

The bulk of psychiatric treatment being given in the community with referral to the State hospital only when long-term treatment was needed.

Payment of much of the cost through the same devices used to pay for the costs of physical illness, including a significant use of prepayment insurance.

New opportunities to treat the long-term patients in State institutions and make the State hospital truly a hospital and not just a custodial warehouse.

New opportunities to change public attitudes toward mental illness as hope replaced the hopelessness of the past, as friends and relatives recovered either without hospitalization or after relatively brief inpatient treatment, and as good news of the revolution in the care of the mentally ill spread.

The greater involvement of the nonpsychiatric physician in the care of the mental patient in the community and the greater utilization of the public health resources of the community in prevention and early identification of mental illness and in the followup care of former hospitalized patients.

These possibilities led logically to the concept of the community mental health center. This is not a concept of just a single new building called a center. It is, rather, a constellation of services working together to provide timely and appropriate care for the mentally ill—a configuration of facilities and services so that no one in need of help is denied the prompt and effective treatment that we now know how to give.

As a result of the planning activity which has been going on in all of the States for the past 2 years, stimulated by the Federal matching grants for planning which the Congress authorized, State officials and citizens throughout the Nation are ready to move to put into operation the new concept of community care of the mentally ill. It is most encouraging to me to note how government at the State and local level has involved the citizens in this planning operation. It is estimated that more than 25,000 people have been brought into the planning activities for community care of the mentally ill.

I am sure that others, currently involved in the administration of public programs at the National and State levels, will testify here that the States are reluctant to apply for Federal funds for the construction of community mental health centers because they are not able to provide immediately the funds necessary to operate the centers. We cannot allow this new concept—this bold new

program for the care of the mentally ill—to bog down for lack of the initial funds for staffing the services. Initial Federal funds to help in both the construction and staffing of community mental health centers were integral parts of the mental health program proposed by President Kennedy. Only half of the job was done 2 years ago when Congress authorized funds for construction under Public Law 88-164. Now President Johnson has called for completing the package by providing funds to assist in staffing the centers.

Every enterprise in its early stages needs working capital, without which—though its services or products be the finest available—the prospects for success are negligible. This is all we are asking for in requesting passage of this bill. We need the staff before we can operate; and we must begin operating before we can have the funds to finance the necessary staff to make the operation possible.

I hardly need remind any of you here that we must succeed. Contemplating failure of the national program, which we cannot really allow ourselves to do, would mean complete chaos.

Just one example of a possibility can, I think, illustrate the perilous dilemma facing us. This is the case of the youngster with emotional illness.

A recent study has shown that there may be as many as 500,000 children with psychoses or borderline conditions. Another million suffer with various serious mental disorders. Some 500 of these children commit suicide each year.

Many workers in the field of medicine find the disturbed child unresponsive and too difficult to work with, because of the emotional drain on the physician.

Where can the mentally ill child of today go? The parent who wants to keep the child at home while he is treated finds a great shortage of clinics or day hospitals, and those that exist have long waiting lists. He also finds that 9 of 10 school systems have no special programs for the disturbed child, and cannot deal with him in regular classes.

Private homes for these children are both scarce and, of necessity, expensive. We have found that fees range from around \$200 a month to \$1,200.

The average family is, therefore, forced to resort to State mental hospitals. More and more of the total State hospital populations are now made up of children and adolescents. Only a small percentage provide effective programs of treatment and only one State in five offers separate facilities with good programs of therapy for these young people.

Unfortunately, most of the disturbed children are housed with mentally ill adults. Many physicians feel this is hard on the adults, and damaging to the children, who in this setting have only the emotionally disordered adult with whom to identify.

Center programs would take into account this need and through early diagnosis, treatment, and community services would hopefully do much to cut the number of future adult patient populations in State hospitals.

This is only one example, but it is one of the most dramatic. For, as Secretary Celebrezze said, if the current trend of child and adolescent admissions to State hospitals continues their population in the hospitals will have more than doubled in the decade between 1960 and 1970.

Mr. Chairman, I realize that my involvement in this program is deeper than most, but I also feel that my understanding is as deep as any.

The time has come when the accumulated knowledge, abilities, and skills acquired over years of endeavor in behalf of the mentally ill can come to fruition.

H.R. 2985 will eliminate further delays, delays we cannot brook. The members of this committee can take the first step toward its passage.

Speaking for the National Association for Mental Health and for myself, but most of all for the mentally ill whom I have served all my professional life, I heartily urge that this committee recommend to your colleagues in the House passage of H.R. 2985.

Dr. FELIX. I thank you, Mr. Chairman.

Mr. Chairman and members of the committee, my name is Robert H. Felix; I am a psychiatrist and a past president of the American Psychiatric Association. I served as Director of the National Institute of Mental Health from its inception in 1949 until mid-1964. My present position is dean of the School of Medicine at St. Louis University, St. Louis, Mo.

As a volunteer I serve as second vice president of the National Association for Mental Health, and today I appear on behalf of that organization to testify in favor of the passage of H.R. 2985.

I might say, to complete my pedigree, that I am also a member of the Missouri State Mental Health Commission.

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In my years as Director of the National Institute of Mental Health, I had many occasions to collaborate with the National Association for Mental Health and I found their lay and professional leaders competent and dedicated. The association was a valuable ally in our efforts at the Federal level to support research, training, and demonstrations in the mental health field. I now serve not only as a vice president of the NAMH but I am also a member of its Professional Advisory Council. My colleagues on the council include some of the most respected and distinguished professional mental health leaders in the country.

The NAMH strongly endorses H.R. 2985.

I might say here that to the best of my knowledge no professional organization of which I am a member—and I am a member of a number—which has taken any position one way or the other on this bill has taken a position against it except the American Medical Association.

In our opinion passage of this measure and its companion piece in the Senate, S. 513, is necessary to complete the first essential steps in the "bold new program" requested by President Kennedy in his historic message to the Congress on mental health and mental retardation on February 5, 1963. I had much to do with the framing of those recommendations and I know that the staffing recommendations were regarded as equally important as the construction recommendations. As you know, the construction funds were authorized in Public Law 88-164 but the staffing provisions were not adopted. Now, as President Johnson recommended in his health message of January 7, 1965, the time has come to authorize Federal funds to assist in meeting the initial costs of personnel for community mental health centers.

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chologists, nurses, and social workers. Although we are still short of the total numbers needed, significant progress has been made, and we know that the trained personnel can be available in sufficient numbers to man the centers when they are ready to open.

The 1962 NIMH report to the Congress showed that in the decade from 1950 to 1960 the number of persons with recognized graduate training in the 4 basic mental health disciplines—psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing—rose from 12,000 to 44,000, an increase of 350 percent.

The 1964 NIMH training report to the Congress noted that the annual number of NIMH training stipends had risen to 7,000. That means in that year there were 7,000 different individuals receiving stipend assistance, and it does not account for others who were in training programs but were not on this particular assistance program. In 1948, the number was 219.

In 1958 the Congress authorized the beginnings of a broad training program in psychiatry for the general practitioner. In the first year of the program—fiscal 1959—only 94 nonpsychiatric physicians were enrolled in the 3-year residency program. In the current year, more than 500 physicians are in residency training courses which will lead to their certification as psychiatrists.

Of even more importance—under this same program, its second part—more than 15,000 physicians have been enabled to take post-graduate courses in psychiatry.

That is, to continue in their practice, whether it be general practice or one of the specialties, but with much greater ability to deal with the psychiatric problems in their practice.

This represents real progress in meeting the manpower problem in mental health.

In recent months in my new role, that of a medical school dean I have become increasingly aware of the growing interest in mental health among medical students. I note increasing numbers of students who wish to explore the possibilities for careers in psychiatry. And I don't believe that this is just a desire to please the dean although I am suspicious in some cases. I think that is a minor motivation.

The current manpower problem is serious but it is certainly anything but hopeless—especially as new efforts are being made by the American Medical Association, the American Psychiatric Association, and the NIMH to help nonpsychiatric physicians carry a greater part of the care of the mentally ill.

It was my great good fortune to have been head of the NIMH as the concept of community care of the mentally ill evolved. New methods of short-term intensive treatment made it possible to challenge the traditional procedure of sending the mentally ill away to large distant State institutions. They rendered archaic the concept of the mentally ill as the "wards of the State" who must be maintained for long periods of time at State expense in isolated mental hospitals. The new drugs and other treatment methods made it possible to conceive of treating the mentally ill on much the same basis as we treat the physically ill—to move the care of the mentally ill back into the mainstream of medicine.

These developments opened up a whole new range of challenging and exciting possibilities which led logically to the concept of the community mental health center.

This is not a concept of just a single new building called a center. It is, rather, a constellation of services working together to provide timely and appropriate care for the mentally ill, a configuration of facilities and services so that no one in need of help is denied the prompt and effective treatment that we now know how to give.

As a result of the planning activity which has been going on in all of the States for the past 2 years, stimulated by the Federal matching grants for planning which the Congress authorized and which I might say terminated after 2 years, and there has been no attempt to continue it as a Federal grant program—the State officials and citizens throughout the Nation are ready to move to put into operation the new concept of community care of the mentally ill. It is most encouraging to me to note how government at the State and local level has involved the citizens in this planning operation. It is estimated that more than 25,000 people have been brought into the planning activities for community care of the mentally ill.

I am sure that others, currently involved in the administration of public programs at the National and State levels, will testify here that many potential applicants, both public and private, are reluctant to apply for Federal funds for the construction of community mental health centers because they are not able to provide immediately—and I emphasize immediately—the funds necessary to operate the centers. We cannot allow this new concept, this bold new program for the care of the mentally ill, to bog down for lack of the initial funds for staffing the services. Initial Federal funds to help in both the construction and staffing of community mental health centers were integral parts of the mental health program proposed by President Kennedy. Only half of the job was done 2 years ago when Congress authorized funds for construction under Public Law 88-164.

I might say I feel somewhat like Moses in the last chapter of the Book of Deuteronomy when Moses went up on Mount Nebo, and was told, to look out over the land of Canaan, but the Lord said “You shall not go over thither,” I got closer, but I didn’t go there; first we didn’t get the staffing provision, and then I had to retire.

That is the only way in which I resemble Moses, incidentally. Now, President Johnson has called for completing the package by providing funds to assist in staffing the centers.

Every enterprise in its early stages needs working capital, without which, though its services or products be the finest available, the prospects for success are negligible. This is all we are asking for in requesting passage of this bill. We need the staff before we can operate—and we must begin operating before we can have the funds to finance the necessary staff to make the operation possible.

I hardly need to remind any of you here that we must succeed. Contemplating failure of the national program, which we cannot really allow ourselves to do, would mean complete chaos in the mental health area. I remind you gentlemen of the committee, Mr. Chairman and gentlemen, that the public mental hospital populations in this country has dropped over 12 percent in the last 10 or 12 years, I have forgotten exactly which, this last year was the largest single drop, about 2 percent. But I warn you, these statistics are going to catch up with you. The population is rising rapidly enough so that if we cannot find ways to stop these patients from going in, we are going to find the hospital population beginning to rise again by sheer force of

numbers of people, though the rate of attack of illness remains the same, or even if it drops somewhat, for if the number per 100,000 of the general population who are ill remains the same the number of hundred thousands of the population are increasing.

Just one example of a possibility can, I think, illustrate the perilous dilemma facing us. This is the case of the youngster with emotional illness.

A recent study has shown that there may be as many as 500,000 children with psychoses or borderline conditions. Another million suffer from various serious mental disorders. And I would call your attention to this. Some 500 of these children commit suicide each year. These are children.

Many workers in the field of medicine find the disturbed child unresponsive and too difficult to work with, because of the emotional drain on the physician.

Where can the mentally ill child of today go? The parent who wants to keep the child at home while he is treated finds a great shortage of clinics or day hospitals, and those that exist have long waiting lists. He also finds that 9 of 10 school systems have no special programs for the disturbed child, and cannot deal with him in regular classes.

Private homes for these children are both scarce and, of necessity, expensive. We have found that fees range from around \$200 a month to \$1,200.

The average family is, therefore, forced to resort to State mental hospitals. More and more of the total State hospital populations are now made up of children and adolescents. You would be interested to know that the age group showing the highest rate of increase in the State mental hospitals is the age group 15 years and younger. Only a small percentage of the institutions provide effective programs of treatment and only one State in five offers separate facilities with good programs of therapy for these young people.

Unfortunately, most of the disturbed children are housed with mentally ill adults. Many physicians feel this is hard on the adults, and damaging to the children, who in this setting have only the emotionally disordered adult with whom to identify.

Center programs would take into account this need and through early diagnosis, treatment, and community services would, hopefully, do much to cut the number of future adult patients in State hospitals by attacking their problems while they are still children.

This is only one example, but it is one of the most dramatic. For, as Secretary Celebrezze said, if the current trend of child and adolescent admissions to State hospitals continues, their population in the hospitals will have more than doubled in the decade between 1960 and 1970. Sometime today I heard the remark about the drain on the taxpayers, and could we afford to do this. I am reminded that in St. Louis County where I am living now we are worried about police protection, and it is going to cost us some more money, but if we don't get it we are going to have more houses broken into and have more people knocked in the head. I say if we don't have more people working at this—and this is the way we can get at the problem—we are going to have more sick children as well as sick adults.

Mr. Chairman, I realize that my involvement in this program is deeper than most, but I also feel that my understanding is as deep as any.

The time has come when the accumulated knowledge, abilities, and skills acquired over years of endeavor in behalf of the mentally ill can come to fruition.

H.R. 2985 will eliminate further delays, delays we cannot brook. The members of this committee can take the first step toward its passage.

Speaking for the National Association for Mental Health and for myself, but most of all for the mentally ill whom I have served all my professional life, I heartily urge that this committee recommend to your colleagues in the House passage of H.R. 2985.

Thank you, sir.

The CHAIRMAN. Dr. Felix, thank you very much for your statement. We appreciate it. We appreciate your interest in this program. I am certain the experience you have had is very valuable in this field.

Any questions?

Mr. PICKLE. You made one statement, Doctor, that everyone was for this except the American Medical Association.

Dr. FELIX. I didn't quite say that.

Mr. PICKLE. What did you say?

Dr. FELIX. I said of those professional societies to which I belong—and I belong to several—of those which have taken a position—and many have not taken one one way or the other—I know of no one but AMA which has taken a position against it.

Mr. PICKLE. The import of your statement was that the AMA was the only group that is opposing it?

Dr. FELIX. As far as I know, that is true.

Mr. PICKLE. I don't want to be misunderstood myself, because I think 2985 is a good bill in its outline. But the American Medical Association's objection was to the matching provision of funds for the staffing of these buildings rather than against the bill or the principle of the bill, is that not correct?

Dr. FELIX. Yes, sir. The other part of the bill is the law, the construction. That was passed 2 years ago. And this is an amendment to that, if I understand correctly. And this they oppose.

Mr. PICKLE. And while granting of the staffing fund is a principal objective of this measure, at the same time the AMA was not saying that they were against mental health clinics, you didn't intend to mean that?

Dr. FELIX. No, I did not. I know to the contrary that this is not so. They are as dedicated to this as any other group.

Mr. PICKLE. That is all.

The CHAIRMAN. In that regard, Doctor, I believe Dr. Carter asked a question earlier about the comparative cost of the staffing of a center of this kind, and the construction of a center. So, have you any experience in that field or any knowledge?

Dr. FELIX. I can recall, I think, our testimony 2 years ago when I was Director of the Institute, and we were testifying on the original bill. If there have been changes since then I can't be responsible for that. As I remember, we calculated the cost of construction, if you constructed de novo and constructed the whole center, as \$1.3 million. And I believe that we calculated the operating costs if you provided the essential services, inpatient, out patient, transitional services, emergency services, and consultation and educational services, that

the total operating cost was about \$800,000, or a little more than half of the construction costs, and 75 percent of the operating cost was staffing. So that would be \$600,000, which would be the cost of staffing.

So the staffing cost in 2 years would nearly come up—yes, the staffing cost in 2 years would be almost as much as the cost of the original construction.

The CHAIRMAN. The total staffing cost for a period of 2 years would be similar to the original cost of the facilities?

Dr. FELIX. Yes, sir. We have estimated \$1.3 million and the cost, and \$600,000 as the staffing cost per year. And that would be \$1.2 million. That is within a hundred thousand.

The CHAIRMAN. I wanted to try to clear that up if I could.

Mr. CARTER. I want to compliment the doctor on his excellent presentation.

I believe the medical association has altered its stand just a little bit on that, especially on the basis of its need. And I feel like I have to support the bill. We have to take care of those youngsters and the psychotics and so on.

Dr. FELIX. I don't want anyone to think I don't heartily support my medical association, I have been active in it for many years. I don't agree on all points. And this is not only true of me but certainly others at one time or the other.

Mr. CARTER. I don't disagree with them; but I want to see the psychotics taken care of.

Dr. FELIX. God bless you, sir; spoken like a true Kentuckian and physician.

The CHAIRMAN. I said earlier when Dr. Appel and Dr. Long were testifying, 2 years ago when they appeared and testified on the program. I believe he was doing the testifying for the American Medical Association, and he had with him at that time Dr. Beaton. And at that time, as I said earlier to Dr. Appel, they were not certain as to what their position was. During that testimony 2 years ago, Dr. Hudson said, "Whether the Federal Government should provide funds for staffing is a question we cannot resolve within the limited time we have to consider this measure. Which viewpoint?" said Dr. Hudson, "holds that such Federal financial assistance during your earlier years would enable the community mental health center to undertake a properly staffed program from the start. Further, within a short period of time the influx of patients and the probability of State funds from other institutional facilities would make continued Federal financial support unnecessary."

And he went on to say that many communities do not have the resources, just as you have said, Dr. Carter, to pay the initial staffing cost needed to insure a successful program. And the principle is conditioned upon the 4-year limitation placed on the Federal participation.

The second viewpoint, which showed that there were differences of opinion, maintains that the Federal participation under the bill should be limited to the construction cost of the community health center.

So Dr. Hudson was giving us just what had been expressed here. That there was a sharp difference of opinion within this organization, but the prevailing viewpoint was as he testified today.

Dr. FELIX. You remember Dr. Hudson was and still is a member of the board of trustees of the American Medical Association. Dr. Beaton is a member and vice chairman of the council on mental health, and Dr. Woolman was the staff officer.

I might say that there are 14,000 psychiatrists who are members of the American Psychiatric Association, and members of the AMA and to the best of my knowledge very few of those, I don't know of any, but there are probably some of that number who oppose this. So it is not unanimous in the rank and file of AMA.

The CHAIRMAN. Of course, there is nothing wrong in having different viewpoints.

Dr. FELIX. That is right, sir.

The CHAIRMAN. And I am glad that we have that privilege in this country. And this committee would be in a terrible shape if that weren't the case.

Dr. FELIX. I wouldn't want to live in a country that didn't have a two-party system, and that means two points of view.

The CHAIRMAN. Any further questions?

Mr. Farnsley?

Mr. FARNSLEY. Doctor, you are a member of the Council on Mental Health of the American Medical Association?

Dr. FELIX. Yes; I am. I am not speaking for the American Medical Association, obviously.

Mr. FARNSLEY. I know that.

Dr. FELIX. Nor am I speaking for the council.

Mr. FARNSLEY. Has the council acted on this? Or is that a secret? I don't want to ask questions that I shouldn't ask.

Dr. FELIX. I have missed the last two meetings of the council. One of them is in Chicago today, and I thought this took priority.

To the best of my knowledge, the council on mental health has taken no action since 2 years ago when it unanimously voted to support this—

Mr. FARNSLEY. This staffing?

Dr. FELIX. Support the whole bill as it originally was written, which was construction and staffing. They were both in the original bill 2 years ago. This was sent to the board of trustees, and the result of this was what the chairman reported just now, where Dr. Hudson commented on there being a division of minds in the board of trustees. I do not know if the council has taken any other action since. They have not when I have been there. I have not been there for the last two meetings.

Mr. FARNSLEY. Unless they have reversed themselves?

Dr. FELIX. Unless they have reversed themselves there has been no change.

Of course, this is only a council.

Mr. FARNSLEY. What does that mean?

Dr. FELIX. A council is a subdivision of the American Medical Association set up to deal with some professional or technical areas. We have one called the council on drugs, and they have one on medical education, and one on hospitals, and maternal and child care, and the council on mental health and so forth. A council may be responsible to either one of the two houses of the American Medical Association. My council, the one on which I sit, is responsible to the board of trustees. Others will be responsible to the house of delegates, which is a larger body and which is the body which has the final say, I might

say, in all matters of policy in the American Medical Association.

Mr. FARNSELEY. It is the one that decided the policy of these statements today?

Dr. FELIX. Yes, sir; in Atlantic City.

Mr. FARNSELEY. Thank you, Mr. Chairman.

Dr. FELIX. Thank you, Mr. Farnsley.

Mr. PICKLE. I would like to ask the Doctor one other question, if you will permit, Mr. Chairman.

The main problem is the financing, of course, of this particular bill. And in the testifying for the bill you obviously recommended that the Government finance the staffing, as it calls for here, for 5 years. At the end of that time, do you personally feel that this should be a responsibility that the local communities could and should take over?

It is not 5 years, Mr. Pickle, it is 4 years plus 3 months. And there is some technical reason for this 3 months that I never quite understood but it gets you on schedule someway. But I am completely in favor of termination at this time.

I was Director of the National Institute of Mental Health for 20 years, or its predecessor. I held that job for 20 years until I retired, and this was a principle that I adhered to in all of the programs over which I had any responsibility.

I am very proud of the fact that there is no question from our place or from any place so far as I know as to a continuation of the planning grants. We came to the Congress and said, we want this for 2 years, and 2 years only, and we never even asked for an extension. If this were to come up as a continuation, that is, to go on indefinitely, I would ask to be heard to oppose it. I was born and raised in Kansas, and I am living in Missouri, and if you know anything about that part of the country, we believe in doing things for ourselves, but we are not going to let a neighbor go hungry or anybody else if we can help him and he can't help himself.

I think this is, if you will, grubstake money. This gets you on the road, and from there on you take it on your own.

And this is why when we originally planned this, Mr. Pickle, I had insisted—I was very strong for a rapidly decreasing participation by the Government. It is sort of insurance in which you take a certain deduction at first and it gets bigger as you go along.

Mr. PICKLE. This bill provides, Doctor, for an open end authorization. In your opinion do you think that we should have some kind of a ceiling on the funds that are appropriated?

Dr. FELIX. I really don't know what to say, because I don't know what the circumstances were. And I am not trying to stick up for the administration. It is a most wonderful feeling in the world. I am a private citizen, and I can say what I feel, I am retired, so I am not bound by any restriction. But I really don't know what was back of it. I just don't know what to say. I would not feel upset either way. And the reason I say this is, if there were no ceiling, I know, because I have appeared before these committees for 20 years, that the Appropriations Committees of the two Houses would take care of the ceiling very well for you, in addition to the administration. So you are not going to run wild anyway.

So I am not worried about that. And with all respect to the gentlemen of the Congress who are here, I would say that after all even if there is not a ceiling, you put one on anyway. And as long

as you feel that it should not go above a certain figure, it does not matter whether it is written in the law, as I see it. I have operated under both kinds of programs.

Mr. PICKLE. Either way you would be satisfied?

Dr. FELIX. Either way I would be satisfied, because I have absolute confidence. I couldn't have more confidence in the Director of the National Institute of Mental Health or his staff or in the Surgeon General, both of whom I have known for many years, and in the Department. And I certainly know a good number of the members of the Appropriation Committees of the two Houses. I have no worry.

Mr. PICKLE. Thank you, Doctor.

The CHAIRMAN. The very fact that we have a matching provision which would place a ceiling on the percentage which we match puts a ceiling on the amount that can be used for that purpose.

Dr. FELIX. That is right.

The CHAIRMAN. So we have a ceiling.

Dr. FELIX. You have a certain check, Mr. Chairman. You can only make these grants to centers that you happen to build, or those that you are building up services for so that they can build.

I believe that is right.

This puts an automatic ceiling on how large it would be, in addition to a percentage variation.

Mr. FARNSLEY. Mr. Chairman, I am familiar with the foundations practice, and you are probably too. In other fields and universities, and what not. Many, many grants are for 5 years to get a program going. And on rare occasions this is extended. I know one case in the University of Louisville Southern Police Institute—this was an unusual situation, it was set up to give training to the picket police of the South, they were going to train them in all kinds of police work, but it was primarily set up to train them for integration—this was very expensive, it cost almost as much as a medical school to do it. But the foundation has discontinued this.

But is this true in the medical schools, do the foundations give 5-year programs and then quit, or sometimes extend them for a period of time?

Dr. FELIX. They do. And so does the NIMH. There is a time limit for 3 years, 5 years, I know in no case more than 7. And in many cases where this is to kick off a program it will be in decreasing amounts. I have seen many of these in which each year we would decrease the amount so that the recipient organization would pick up the difference and final phase in the whole thing.

Mr. FARNSLEY. I want this in the record, because whereas people in the Government are used to thinking that if something once gets in the budget it never gets out, the men that will be staffing these, are used to the system whereby it terminates, and that is it.

The foundations have done great work to get good things going, and then the local university, or whatever it is, takes them over after 5 years. So I don't have the fear that many people have that this thing will keep on forever.

The CHAIRMAN. Thank you very much. Again, on behalf of the committee, we appreciate the valuable contribution you have made in your presentation and we are delighted to have you back with us, Doctor.

Dr. FELIX. Thank you, Mr. Chairman. It makes me homesick to be here.

The CHAIRMAN. At this point we will put in the record the statement of Charles H. Frazier, of the National Association for Mental Health. (The statement referred to follows:)

STATEMENT OF CHARLES H. FRAZIER, MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, ON H.R. 2985

My name is Charles H. Frazier. I am a resident of Downingtown, Pa., and an independent consultant in the public utility field with offices in Philadelphia. I am here today to testify on behalf of the National Association for Mental Health and its 800 county and State subdivisions, with enrolled membership and associated volunteers of more than 1 million people. I am a member of the board of directors of that association and of Pennsylvania Mental Health, Inc., its State division, having been president of that organization for some years. I am also chairman of the board of directors of the Philadelphia General Hospital, the municipal hospital in Philadelphia, which has an active psychiatric service operated in conjunction with the Commonwealth's mental health system.

Our particular interest in this legislation comes not only from our long-term interest in improving the conditions of the mentally ill, but also from the experience of that association during the past 2 years in assisting the various States in the comprehensive mental health planning program which has been underway. I, myself, am on the executive committee of the Pennsylvania Planning Organization and am chairman of its subcommittee on community organization.

My organization—the National Association for Mental Health—has a 50-year record of interest and work in this important field. In 1909 the National Committee for Mental Hygiene was organized; then in 1950 our association was organized under its present title. We have been before you many times testifying as to measures in the mental health field. We urged you to enact, what became in 1946, the National Mental Health Act. We have supported the appropriation measures for the National Institute of Mental Health. More recently we appeared before you encouraging you to enact what was then House bill 3688, as to which this committee held hearings some 2 years ago.

At that time, we laid great emphasis on the progress in the mental health field, over the 54 years of our existence. When Clifford Beers organized the national committee, the conditions in the State hospitals—the “lunatic asylums”—were such as to arouse horror among the doctors and interested citizens and, when they finally were made aware of this, among legislators at the State and then the national level. Since that time great progress has been made in the States' hospital systems; but as you have been told many times, this progress has barely kept pace with the increased severity of the problem.

Several years ago, with the publication of “Action for Mental Health,” under Federal auspices and with the best brains of the profession contributing, a blueprint was available for more adequate care for the mentally ill, and you in the Congress and we in the States embarked on the first steps toward making a realization out of this blueprint. First, you made substantial sums available for comprehensive planning in the States—a program now well on its way to completion. Second, in the passage of Public Law 88-164, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, you established as a national goal the creation of a network of community mental health centers and provided for Federal matching funds to assist in their construction. You did this with the realization that the new emphasis in the treatment of the mentally ill must be on the prompt and effective attention to their problems in the community in which they live, and not subject them to the frequently traumatic experience of admission to a State hospital many miles away, where all too often they stayed for months and, indeed, years.

The principal emphasis of a community-based mental health program must, however, be on personnel and not on buildings. True, construction funds will be required in many areas and, particularly, in my State and elsewhere, in regions some distance from the major urban centers. Even in these places, however, and certainly in the large cities, emphasis must be on tying together existing service programs into a coordinated whole; on amplifying these programs to make them truly comprehensive; and on making them available to all the people of the community. But this takes people—you have heard the phrase “brains plus bricks”—and it is the brains, unfortunately, as to which the legislation passed last year did not address itself. It is to remedy that situation that the current legislation, H.R. 2985, has been introduced by your chairman.

I would like particularly to discuss this legislation from the standpoint of one very directly involved in the comprehensive mental health planning process now underway in all the States. There are two questions which are continuously being posed to us by the hundreds—indeed thousands—of people involved in the planning process in one way or another in Pennsylvania. The first, of course—where are we going to get the people; and, second, where will the money come from.

Let me turn to the first question. I am not as depressed about this prospect as I might be, had I not taken a look backward, over the last decade, to see how far we have come, at least in the State mental health system—leaving aside the substantial development in therapy under private auspices. I asked for the record of how the professional staff in the State system has grown over this 10-year period, and received this very encouraging word: That in the three categories of physician, psychologist, and social worker, Pennsylvania has been successful in doubling this personnel during this space of time, moving from the total of 276 people in 1955 to 528 people in 1964, with each category showing substantially the same great advance. It is quite clear then that people are coming into these critical healing professions. They are attracted to this profession by the knowledge that in equipping themselves to serve here, they are getting ready for a rewarding and constructive life, and meeting a great social need. They are being trained, with the help of the National Institute of Mental Health, in ever greater numbers, in the various professional schools. Nor is this record in Pennsylvania atypical of national progress. It is quite likely that in the first few years in which the community mental health center program moves into high gear, there will be a great scramble for able personnel, but this need need not be of too great concern for we may be confident that in time, the ranks will be filled.

Having said this, however, I must hasten to add that the problem will be severe as we change our treatment system from emphasis on large State hospitals to emphasis on community resources. Just as the treatment will be more active and more successful, so, more professional man-hours will be required. It is here that the value of community-based programs poses both a problem and a solution. Not only in the big cities, but in the smaller communities as well, there are many professionally trained people who will be useful to the program, but who will not want to work, for one reason or another, exclusively either for a tax-supported agency or, indeed, for a single institution. There are many, many more private psychiatrists in Philadelphia than there are in the public service; there are many more psychologists; and most social workers are employed by the various private agencies. Were this to be an attempt to enlist a large additional force of professional people—including that very scarce category of the psychiatrically trained nurse—in institutions some distance removed from the cities, on a full-time (and often not too well paid) basis, it might very well result in failure. However, the reason why I said the community program not only presents a challenge but also a solution, is that we see the development of these programs as not only utilizing to the maximum the agencies presently engaged in one aspect or another of the complex of services in the mental health field, welding them into a better coordinated and more productive structure, but we also see it possible to attract to this coordinated service, many more people on a part-time basis than would be possible if the alternative were similar to the State hospital system.

In the field of nursing, for example, where there is a tremendous shortage—not only, of course, in the hospitals for the mentally ill but throughout the field—the greatest untapped resource is in the married nurses who have left the profession but are ready to go back either because their children have grown or because their family situation permits them working full or part time. They need to be brought back into this professional field, not only to prevent the tremendous waste of public funds in their original training, but also if the nursing rosters are to be filled. Only with a community-based mental health program would a recruitment effort of this sort meet with any degree of success. The same logic applies as one passes along through the other various skilled professions needed.

To sum up, community-based programs, while requiring a more extensive program of professionally trained people, will make it possible both because of geography and because of the articulation between public and private agencies to attract many skilled people for part-time and, indeed in some cases, full-time service who would otherwise be unavailable.

The second question, of course, is where are we going to get the money. Here again the record of the States has not been too discouraging in finding funds, when we look back over the years. Admittedly, we in Pennsylvania started from a pretty low level 10 years ago, but the funds appropriated for the department of welfare's program for mental health and mental retardation have in-

creased from \$53 million to \$124 million just in this space of time. The taxpayers in Pennsylvania, convinced of the value of the program, have somehow found this money.

You may ask then, why the emphasis on the great need for temporary Federal support, or the corollary question of what assurance do we have that what we are seeking is really temporary.

I think the answer to these last two questions is the same. We have shown that public support can be built up for a mental health program, but it takes time. Both the State and local governments are presently in a severe tax-bind to find the funds necessary to provide the expanding level of services the citizenry demands. With the very heavy commitments in the mental health and mental retardation fields, if we were to attempt, in Pennsylvania, to finance the creation of a network of community mental health centers on top of the current State program, and with the dearth of additional tax funds available, these centers would be a long time in coming. On the other hand, if these funds can be temporarily made available as a result of the legislation now before this committee, it may reasonably be expected that the program can be established promptly and effectively, and that the States can begin to pick up this new financial burden year by year as the pressure for increased funds in the State hospitals decreases. We are not saying that, in Pennsylvania for instance, we will need less funds in State hospitals during the next few years, but rather that the growth rate in appropriations need not be repeated and that as the Pennsylvania economy grows and is better able to fund its public welfare services, a part of these additional resources can be devoted to the community mental health centers program. The same logic can be applied to the share of the community mental health centers program which will be carried by the local taxing units. Nor is what I say for Pennsylvania not valid for the other States as well.

I would like to make one additional observation with respect to finances which I believe to be pertinent. This is a day when catastrophic medical expenses are more and more covered by insurance and other forms of prepayment. Blue Cross and Blue Shield plans abound, and, indeed, this 89th Congress is considering additional insurance plans with respect to medical care for people on social security. In this field, we have a record of increased acceptance of the Blue Cross systems, and of the extension of the coverage for hospitalization to coverage for mental illness. We can confidently expect that insurance will carry a larger and larger share of the cost of hospitalization, and since much of the hospitalization in the community will be in institutions where Blue Cross now picks up a large part of the tab, this form of financing will, in the future, become more available.

And then I would like to mention, in closing, another form of "insurance" or prepayment about which we may hear much more in future years. The UAW in its recent negotiations with the motor companies have signed a landmark contract which covers not only hospitalization for its employees and their families for mental illness, but also covers outpatient treatment in clinics. To the extent that more and more union members receive this kind of coverage, we can expect the community-based mental health facility to receive a substantial part of their support from union-sponsored health and welfare funds and contracts.

And so I say to you that, as with manpower, funds will be available in the States and communities throughout the land if we are given time to create the programs, and educate the public as to their value by proving their usefulness. But a beginning must be made, and it is here that the Federal Government can be of such tremendous help. As with the pilot programs of the National Institutes of Health, and in particular mental health, so with this community mental health program, what we in the States need is the encouragement and initial support, and you may count on us to do the rest.

The time for action is now. Since we know how to treat mental illness more effectively, it is too wasteful of both funds and of the human resources of the individuals and families involved to continue the process of putting the ill away in what have been characterized as human dustbins, when we can keep these same people in the community, in many cases still at work and earning a living, and cope with a large part of the problem of mental illness in this constructive way.

The CHAIRMAN. The committee will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 5:45 p.m., the committee recessed, to reconvene at 10 a.m., Friday, March 5, 1965.)

RESEARCH FACILITIES, MENTAL HEALTH STAFFING, CONTINUATION OF HEALTH PROGRAMS, AND GROUP PRACTICE

FRIDAY, MARCH 5, 1965

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met at 10 a.m., pursuant to recess, in room 1334, Longworth Building, Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will please come to order.

This morning, as we resume hearings on the four bills proposed by the Department of Health, Education, and Welfare, we have as the first witness, our colleague on the committee, Hon. John J. Gilligan, of Ohio. Mr. Gilligan, we will be glad to hear you at this time.

STATEMENT OF HON. JOHN J. GILLIGAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. GILLIGAN. The purpose of H.R. 2985 is to provide the basis for a working partnership between the Federal Government, the governments of the several States, and organizations in local communities for a joint effort to develop what Secretary Celebrezze has termed "a bold new approach" to the problem of promoting mental health and preventing mental illness, the development and staffing of community mental health centers.

The Secretary has further pointed out that this committee's report on the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 emphasized that the program should be "so tailored as not to result in the Federal Government's assuming the traditional responsibility of the States, localities, and the medical profession for the care and treatment of the mentally ill."

In other words, in providing further Federal assistance to States and local communities by providing a portion of the cost of professional and technical personnel for the initial operation of these new centers, the objective is to encourage new and more intensive programs, not to replace with Federal dollars local or State expenditures, and certainly not to provide a screen of new activity in this field behind which State governments can curtail or restrict their activities in the field of mental health.

The Federal Government obviously cannot and should not force the State governments to do anything, but it is well to realize the efforts and dollars of all of us will be wasted unless all the partners in this arrangement press forward with equal vigor, and do all within their power to achieve the goal. If any one of the partners is per-

mitted to shirk its responsibilities, the result will be a fraud on the taxpayers, and a cruel hoax on the families of the victims of mental disease.

For the Federal Government simply to provide matching grants is not sufficient to assure success of any program, if the State receiving them does not respond properly to its duty.

As an example, I point out the case of Ohio in regard to the use of Federal grants during the past year for rehabilitation of the mentally ill. Ohio, for the last several years, has lagged behind in this most important area, though it is a leader in wealth in the Nation. At present, Ohio is 52d out of 54 national jurisdictions in the number of mentally disabled persons rehabilitated per 100,000 persons of population. Additionally, the ratio of vocational rehabilitation counselors is 1 to 138,000 population, while the national average is 1 to 70,000 population. In spite of this fact, though the Federal Government allocated grants of \$4.25 million for rehabilitation of the mentally ill to Ohio in 1965, fully \$2.7 million, or 64 percent of the total grants, were not used simply because the State refused to come up with the matching funds.

Moreover, the State may juggle its bookkeeping methods, and by unilateral action divest itself of a continuing responsibility in a given field of endeavor. For example, Ohio recently adopted legislation implementing ADCU, and began transferring thousands of families from poor relief (a State program) to ADCU (a federally supported program). At the same time, the State, by unilateral action altered the terms of its poor relief program with local governments. Where traditionally Ohio had matched local efforts on a 50-50 basis, the State's effort was cut to 40 percent. In many cases the local governments had no resources to meet the added burden, and family allowances for thousands of people on poor relief were slashed to 70 percent of subsistence. The result of this action by Ohio was that State welfare expenditures were cut back, Federal and local expenditures climbed, and thousands of helpless, poverty-stricken people suffered in hopeless misery.

It must be emphasized that safeguards should be adopted to insure, so far as possible, that the States which would request and accept Federal assistance in these new programs in the field of mental health are really doing a reasonable and responsible job in this field.

The director of the Department of Mental Hygiene and Correction of the State of Ohio appeared before this committee on March 4, 1965, to urge the adoption of H.R. 2985. In his testimony, Mr. Janis said that—

On March 22, 1965, the citizens committee will submit an interim report to the Governor of Ohio. In this report they recommend that Federal funds should be made available to assist communities in the operation of comprehensive centers serving the mentally ill and mentally retarded. They too feel that if a job is to be done, the community, the State, and the Federal Government must join hands in behalf of improved programs for the mentally ill.

Mr. Janis' comment is only one side of the story of that report. Though it is due to be released on March 22, 1965, to the Governor alone, and later to the public, portions of that report have already been reported by the press. In the Columbus (Ohio) Citizen Journal, of February 25, 1965, it is reported that the subcommittee concerned

with manpower had already made its findings known to the chairman of the citizens' committee. In that report these points were made:

(1) The problem of manpower in the area of mental health in Ohio is of crisis proportions;

(2) Turnover of personnel is particularly critical at the supervisory level;

(3) The great loss of professional personnel in the State programs is all the more alarming in view of the rising rate of admissions to State hospitals;

(4) The low pay for psychologists, social workers, nurses, occupational therapists, and vocational rehabilitation counselors does not compare favorably with pay for similar positions in other States.

And most significant, in relation to the problem we are currently studying, the report indicates that:

(5) There has been an alarming and overwhelming loss of personnel in Ohio's State-aided community clinic programs.

The newspaper account indicated that when the director of finance in Ohio, Mr. Richard L. Krabach, was informed of the study, he estimated that it would cost at least \$50 million to put the committee's program into effect. This may be so, for Mr. Krabach should know Ohio's financial situation better than anyone else. Is Ohio, then, making the kind of attempt that is required? The expenditures for mental health in Ohio (not including correction), for the past several years are:

Fiscal 1962.....	\$64, 042, 510
Fiscal 1963.....	67, 792, 810
Fiscal 1964.....	67, 823, 799
Fiscal 1965.....	67, 821, 555
Budget, fiscal 1966.....	74, 745, 000

It should be noted that in fiscal 1963, 1964, and 1965, the amount expended varied less than 1 percent—indeed, the 1965 figure was lower than that for 1964.

But what is not apparent at first glance is that in fact Ohio, for each of these years, was actually falling far behind in mental health services. Statutory requirements for pay raises along with increases in equipment costs, food, medicines, and increases in numbers of patients had to come out of the budget of each succeeding year.

In other words, just to keep the same level of services, Ohio should have been budgeting at least \$4 million more each year. Consequently, by 1964 Ohio was \$4 million below the budget for 1963. By 1965 it was \$8 million below 1963. By 1966 it will have been \$12 million below the standard of 1963, and by the end of fiscal 1966, Ohio will be \$16 million below the standard of 1963. While it is true that there is great pressure on the State of Ohio by citizens groups which has caused a proposed budget increase in this area of more than \$6 million for fiscal 1966, but by the end of fiscal 1966, even if the Ohio Legislature grants the full request of the Governor, Ohio will have fallen \$10 million behind the 1963 level. This is so, even at a time when most other States have increased the expenditures for their mental health programs far above the normal increments required by increased costs of services and construction.

It is interesting to note further how Ohio stands in relation to the other nine major industrial States in the Nation in certain categories.

All ranking below indicate expenditures in public mental hospitals, 1963.

<i>Category</i>	<i>Rank</i>
Total daily expenditure per resident patient-----	10
Expenditure for capital additions and improvements (average daily per resident patient)-----	1 9
Total expenditure for public mental hospitals and public institutions for the mentally retarded-----	2 10

¹ Ohio's daily expenditure was \$0.09; the 10-State average was \$0.22; and the leading State (Indiana) spent \$0.49.

² Ohio's expenditure was \$6.32; the 10-State average was \$9.62; and the leading State (New York) spent \$15.02.

Mr. James A. Connolly, of the Legislative Relations Committee, the Mental Health Association of the Cincinnati area, who did an exhaustive study of mental health expenditures in Ohio, estimates that at least \$29 million more must be spent this year in Ohio for that State to come up to even the average of the second- to fifth-rated industrial States.

It is to be hoped that the State of Ohio then, will not reduce its commitment to mental health because of an increase in Federal dollars, and claim that it is doing the taxpayers of Ohio a service.

It is to be hoped that the State of Ohio will not, as it did in its welfare programs, shift its responsibility for the community health enters to the communities, which could not possibly accept the new responsibility, when Federal grants decline and eventually stop, as they will under the terms of this bill.

It is to be hoped, further, that the State of Ohio will not, as it did in its programs for rehabilitation of the mentally ill, refuse to provide matching moneys to Federal grants in the future for such programs as this one we now consider.

Based on recent experience in my own State of Ohio, it is my firm conviction that the enactment into law of H.R. 2985 may very well provide tremendous impetus to a bold new program for the care and treatment of mental illness, but only if the bill is so amended as to prevent the kind of thing that has happened in Ohio for the past few years.

The CHAIRMAN. Are there any questions? If not, we thank our colleague for his testimony and his interest in this legislation.

Mr. GILLIGAN. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is our colleague from the great State of Hawaii, the Honorable Spark M. Matsunaga. Mr. Matsunaga, we will be glad to hear you at this time.

STATEMENT OF HON. SPARK M. MATSUNAGA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF HAWAII

Mr. MATSUNAGA. Mr. Chairman, thank you for this opportunity to make a statement in support of H.R. 2984 and H.R. 2986.

Mr. Chairman, Hawaii presently lacks a school of public health. This is a rather important fact from the standpoint of community health services and health education and research which such a school is normally able to provide the community and the State in which it is situated. However, since July 1962, the faculty of the University of Hawaii, at Honolulu, has been instructing graduate students, carrying on research, giving service in the community, and conducting continuing education programs not only in Hawaii, but also in other

Pacific island communities such as Truk and Okinawa. Admittedly, such a program is usually offered by a graduate school of public health.

The need for a school of public health at the University of Hawaii has been reemphasized as the result of the present program which we hope will be a transitional one of short duration. Plans already have been made for a new school of public health and it is anticipated that formal accreditation will be achieved by 1966.

The bills under consideration do not, of course, contain specific provisions for the benefit of the State of Hawaii or any other State. I am asking for support of these bills because, being mindful of the needs of our island State, I know that the appropriations provided by these bills will be necessary to sustain and implement the programs which are presently being carried on without the benefit of a school of public health.

I am deeply concerned, however, over the limited nature of the maximum amount of appropriated funds authorized to schools of public health. That amount, I believe, is \$2.5 million. This means that the addition of new schools of public health must inevitably decrease the amount available for existing institutions. In order that Hawaii's proposed school of public health may receive the full benefit and support of Federal legislation, I respectfully urge your committee to seriously consider an amendment to H.R. 2984 by increasing the authorization under section 314(c)(2), Public Health Service Act, from \$2.5 million to \$5 million. The increase is considered to be vital if the University of Hawaii's School of Public Health is to be established as planned.

Thank you very much.

The CHAIRMAN. Are there any questions? If not, we appreciate your appearance, Mr. Matsunaga.

Mr. MATSUNAGA. Thank you, Mr. Chairman.

The CHAIRMAN. Our next witnesses are representing the Association of American Medical Colleges.

Dr. George A. Wolf, vice president, Medical and Dental Affairs, Tufts New England Medical Center, is accompanied by Dr. Thomas Turner, dean, School of Medicine, Johns Hopkins University, and Dr. Robert C. Berson, executive director, Association of American Medical Colleges.

Gentlemen, would you please come forward?

STATEMENTS OF DR. GEORGE A. WOLF, VICE PRESIDENT, MEDICAL AND DENTAL AFFAIRS, TUFTS NEW ENGLAND MEDICAL CENTER, AND DR. ROBERT C. BERSON, EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. WOLF. I regret that Dr. Turner is unable to join us today. If I may, I would like to ask Dr. Berson to speak for the association.

The CHAIRMAN. We are glad to have you, Dr. Berson, along with Dr. Wolf. You may proceed, Dr. Berson.

Dr. BERSON. Thank you, Mr. Chairman.

I have given the clerk a copy of the statement for the association, and with your permission, I would like to have that introduced into the record. Then I would like to make my verbal comments quite brief. Of course, Dr. Wolf or I would like to respond to any questions.

The CHAIRMAN. Very well, Doctor, your statement will be included in the record. You may proceed as you desire.

Dr. BERSON. Thank you, Mr. Chairman.

The association actually views with favor all four of the bills that you are holding hearings on, but the health research facilities amendments of 1965 constitute the focus of our interest and our expert knowledge. We are sure that you will hear from other witnesses about the other bills, and that this will build a better record than we could.

This program, the Health Research Facilities Act, has, in our opinion, been one of the most successful programs that the Public Health Service has been administering for several years. The nearly 1,000 projects that have been helped by this program have been in a broad range of institutions, and the improvement in facilities and, therefore, the upgrading of research in the country, has been really very remarkable.

In all of these institutions, the health research that is going on is accomplishing very great things. We are somewhat biased, you might say, in our interest in medical schools, but the fact is that research in medical schools is of essential importance to the medical schools and to research itself. The presence of the students, the sort of questions they ask, the sort of interest they have, the tremendous stimulus to the investigator, sharpens and improves research and greatly enriches the educational experience of the student, to be exposed in an environment working with teachers who, themselves, are active investigators.

It is not surprising that over half of the funds in this program since 1956 have been awarded in construction grants to medical schools. As you know, from the Department's testimony, the backlog of good applications for construction grants is expected to be about \$80 million by the end of this fiscal year. We think that a simple projection of that amount which, of course, would give you \$400 million in 5 years, understates the need.

There are many institutions that are planning to develop new medical schools, and each one of these have substantial needs. There are other institutions who plan to replace obsolete facilities, and there are still other institutions that plan to expand enrollments and research programs, as well as other programs.

The new medical schools are of particular importance, I think. It was this committee that recommended that the 88th Congress pass the Health Professions Educational Assistance Act, which has been tremendously encouraging and helpful. As you probably know, that program is just getting underway, since the appropriations were only available last September, but this has stimulated many universities to develop plans. In a way, the Research Facilities Act is an essential part of a two-part package, with the Health Professions Educational Assistance Act.

H.R. 2984 also provides the authority for the development of a few research centers of national or regional importance, and we think that that is a very sound provision. There are some instances in which the faculty is interested and competent. A clear national need exists to push forward with research in some areas, but it is extremely difficult for the institution in which these members of the faculties work to find the funds with which to develop such a research

center, or even to match a grant for that purpose. We think this proposed authority is very sound and we hope that you will recommend it.

The act also will give the Public Health Service the authority to contract for research, as some other agencies do. There is a clear opportunity to bring to bear on some of the development of such devices as pacemakers for the heart, or artificial organs, the competence that now exists in commercial, industrial, and engineering organizations. This contract authority we think is sound. We hope you will recommend that, too.

The act also provides for three additional Assistant Secretaries in the Department. We understand it is planned to upgrade the position of the Special Assistant for Health so that this would be upgrading one position and creating two additional ones. Your committee is very familiar with the escalation of appropriations and the responsibility for new programs in this Department.

We think that it is wise for the Secretary to have this additional strengthening of the staff at a high level, particularly because the medical schools of this country see a clear need for the Department of HEW to constantly conduct studies and projections of the needs for health manpower that are already pressing and seem certain to grow in the future. In short, we think that the health research facilities amendments of 1965, H.R. 2984, is sound as it is written, and we hope you will recommend it.

We also favor the other measures you are hearing about, but we are not intimately concerned with them. Either Dr. Wolf or I would be delighted to try to answer any questions that you have.

(Dr. Berson's prepared statement follows:)

STATEMENT IN SUPPORT OF H.R. 2984 ON BEHALF OF THE ASSOCIATION OF
AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges whose institutional members are the medical schools of this country, appreciates the opportunity to express its support of H.R. 2984, Health Research Facilities Amendments of 1965. We consider the other bills on which you are receiving testimony at this time to be important and sound, but you will receive statements from other witnesses whose advice concerning them will be more expert than ours.

Since the Health Research Facilities Act was passed in 1956, awards have been made to nearly 1,000 projects (990 as of Dec. 31, 1964) in schools of dentistry, medicine, osteopathy, pharmacy, public health, veterinary medicine, and in colleges, universities, hospitals, and research institutes. Vast improvement of the facilities for health research in all parts of the country has resulted. Fine things are being accomplished in all of these institutions, but the role of research in medical schools deserves special emphasis.

The modern era of medicine really began when a few medical schools provided opportunity for their faculties to actively engage in research, and selected faculties for their competence in research as well as in teaching and the care of patients. This policy proved remarkably successful and has spread to medical schools throughout this country. The research of the members of the faculty is sharpened and improved by intimate association with students and response to the searching questions of their keen minds. The student's educational experience is enriched by his becoming familiar with the research process and his wise choice of a career is improved. Only a minority of students choose to make a career of research, but the practitioner's grasp of medical knowledge is greatly improved by his having some familiarity with research. It is natural then, that something over half of the funds awarded in construction grants have been to medical schools (\$161 million out of \$319 million).

Since this program began there has always been a backlog of applications which seemed sound to the National Advisory Council. The indications are that this backlog will be about \$80 million by the close of the present fiscal year. A simple

projection of this experience indicates that all of the funds proposed for the next 5 years (\$400 million) will be needed. The Association of American Medical Colleges is convinced that three developments, whose full impact is not yet visible, will increase this need substantially; many institutions need to replace obsolete research facilities, many medical schools are actively planning to expand enrollments and research programs, and the development of a number of entirely new medical schools will require very substantial research facilities.

The Health Research Facilities Act and the Health Professions Educational Assistance Act are complementary programs of the greatest importance to the future supply of physicians and people trained in the allied health professions, as well as the future research programs.

We are also convinced that it is wise to provide for the development of national and regional research centers as provided in H.R. 2984. The fact is that each medical school or university which might provide a proper setting for such a national or regional center is hard pressed to meet other needs that are of more pressing importance for the institution itself. For that reason, in some instances, members of the faculty interested in, and competent to conduct research programs of this sort cannot expect their institution to assign a high enough priority to such a national or regional mission to provide matching funds. It is our understanding that it is planned to make a modest beginning with such centers and to plan very carefully any future expansion, and this seems very wise to us.

We believe that it is sound for the Public Health Service to have the sort of authority H.R. 2984 will provide to contract for certain kinds of research. This authority has been used wisely in other agencies such as the Atomic Energy Commission and the National Aviation and Space Agency, and we believe it will improve the total program of medical research in this country.

We are strongly in favor of the provision for three additional Assistant Secretaries in the Department of Health, Education, and Welfare. The very great expansion of responsibilities and programs in the Department in the 12 years since it was established makes it highly important to expand and strengthen the senior staff in the Department. We understand that it is intended to upgrade the position of the Special Assistant to the Secretary, and that therefore only two additional Assistant Secretaries will be added. The escalation of appropriations to the Department in the past is well known to your committee and a great many of the new programs for which the Department is now responsible have been recommended by you. We would like to emphasize the great and growing importance of provision for trained manpower in the many categories of health personnel, and the importance of the Secretary of Health, Education, and Welfare having the staff to continually study this complex field and make appropriate recommendations.

In short, we are strongly in favor of the passage of H.R. 2984 and see no need to change any part of it.

The CHAIRMAN. Doctor, thank you very much. We are glad to have your presentation here of the views of your organization.

Did you have any further comment, Dr. Wolf?

Dr. WOLF. I would just like to make two very brief points.

One is that the Association of American Medical Colleges represents all of the medical schools in the United States.

The second one is a personal comment that it so happens that a few years ago I was a member of the advisory council for health research facilities and had the opportunity to visit a number of medical schools and research institutions to see what some of the needs are for research construction.

I have also had the opportunity to see what prior legislation in this regard has accomplished, and also would strongly support it.

Thank you.

The CHAIRMAN. How many medical schools do we have?

Dr. BERSON. Eighty-seven, but there are a number in the planning stage.

The CHAIRMAN. How many?

Dr. BERSON. It depends upon how you define it, Mr. Chairman. We usually think of 11. But then there are letters of intent that

have been sent to the Public Health Service for construction grants for a good many other institutions whose plans are just taking shape.

The CHAIRMAN. How successful have we been in increasing the number of doctors graduating from medical school over the last 5 years, Doctor?

Dr. BERSON. Really, our success is very modest, Mr. Chairman. I do not have the detailed figures with me, but it has been a very small increase each year. The impact of the Health Professions Educational Assistance Act is not yet apparent in the figures that we have for either enrollments or graduations, because it has been implemented so recently, but the increase of enrollments has been of the order of about 100 places per year for the last 5 years. I would be happy to supply the detailed figures on this.

The CHAIRMAN. I wish you would supply that for the record.

Does that mean 100 total increase of doctors throughout the Nation?

Dr. BERSON. No, sir. The total number of doctors is a more complicated figure than the number of entering medical students, because the number of graduates of foreign medical schools who are licensed in this country has an effect on the total number of doctors in practice. This number of foreign graduates has been increasing, and is now about 1,600 per year.

The CHAIRMAN. It is increasing 1,600 per year?

Dr. BERSON. For 1 or 2 years it has been at that rate.

The CHAIRMAN. Is that the increased numbers that have come out of medical schools, or is that a total increase, considering those who may have retired, passed on, or for some reason have gone into some other vocation or profession?

I am trying to figure out what is the total result, the net increase.

Dr. BERSON. The net increase of doctors in practice I will have to give you in detail later. It has been a modest increase, about parallel with the increase in the population.

The CHAIRMAN. About parallel to the increase in population percentage-wise or per so many every 100,000 population?

Dr. BERSON. The number of doctors per 1,000 population has been staying about stable for the last 5 years.

The CHAIRMAN. What is that?

Dr. BERSON. This, again, depends upon how you figure it. The Public Health Service has recently had some technical conferences on this. It is in the range of 140 per 100,000. This figure has been approximately stable. If it had not been for the addition of the graduates of foreign schools, the ratio would have declined.

Mr. SPRINGER. Mr. Chairman——

The CHAIRMAN. Mr. Springer?

Mr. SPRINGER. Last year I offered an amendment, or, rather, in 1963, which said: In the case of an application for construction to expand the training capacity of existing schools of medicine, dentistry, and so on, or public health, during the first full year after the completion of construction and for each of the next 9 school years thereafter enrollment must exceed the highest first year of enrollments of such schools for any of the 5 full school years preceding for which application was made by at least 5 percent of such highest first year enrollment out of the 5, or by 5 percent, whichever is the greater.

Are you familiar with that?

Dr. BERSON. Was this an amendment to the Health Professions Educational Assistance Act?

Mr. SPRINGER. Yes, it was.

Dr. BERSON. Yes, I am.

Mr. SPRINGER. Did you make application last year?

Dr. BERSON. I speak for all the medical schools. Dr. Turner, from Hopkins, did not get here today.

Mr. SPRINGER. How much is that amendment going to amount to?

Dr. BERSON. I think it is very difficult to be specific about that. I think that every medical school has very carefully considered whether it can expand its enrollment by 5 or 10 or 20 percent. They are aware that their chances of getting construction grants will be greater if they do expand enrollment.

Mr. SPRINGER. I want to find out what they were going to do in Chicago, and all they said was that they wanted to expand quality. Well, they didn't quite say that, but that was the inference. This was one of the reasons that I put this amendment in here, to be sure that nobody built anything with Federal funds unless they were going to increase the number of doctors per 1,000 population in this country, consistent with what you ought to do.

What was the first-year enrollment last year of all the medical schools?

Dr. BERSON. It was about 8,500. I can give you the accurate figures on that for the record.

Mr. SPRINGER. That would be in the nature of 400, if everybody got an application, wouldn't it? That is about what it would amount to. If everybody got money—did you say 67 or 87 medical schools?

Dr. BERSON. Eighty-seven medical schools.

Mr. SPRINGER. If all of them got it, you would have an expansion of roughly 400 doctors per year.

Dr. BERSON. Yes.

Mr. SPRINGER. Thank you, Mr. Chairman.

The CHAIRMAN. Doctor, we are interested in it. We want to realize the results of the program that has been adopted, approved, and generally accepted as advisable and wise throughout the country.

I ask these questions at this time in consideration of these problems, to find out just what we are doing. I will be interested in the information that you are going to supply for the record. We will analyze it very carefully.

(The information referred to appears on p. 269.)

The CHAIRMAN. I have one other point I would like to bring up.

Yesterday, Mr. Appel, for the great organization well known throughout this country, the American Medical Association, made a statement that they fail to see how research can be classified on a regional, national, or local basis, and, therefore, they thought that the proposal here for regional research centers should be deleted.

It is not too clear in my mind how this will work anyway, and I am not sure whether we should have this kind of center. However, I can see how important it would be for groups of institutions that are in a certain area, as an example, which would include several States, to benefit by such an operation.

In view of the fact that I would like to have more information, I wonder if you have any comment?

Dr. WOLF. May I speak to this, sir?

The CHAIRMAN. Yes.

Dr. WOLF. I think the term is "regional research resource." I am not sure whether that is in the bill or not, but I think this is in the thinking of some of the people that are proposing this. I would like to give you one example of an existing resource, which happens to be in my institution.

This is supported by the Public Health Service, in a rented old factory building, as a matter of fact. It is a resource in that it provides enzymes, which are very expensive to prepare, for the whole New England region. This is operated by the Department of Biochemistry at Tufts University, and it simply manufactures enzymes which are of value to investigators in the medical schools and research institutions and hospitals of the New England area.

That this is a valuable resource, I think, can be illustrated by a very brief description of what went on in our school before, when certain kinds of enzymes were needed. Our professor of biochemistry and some of his staff had to load a station wagon full of ice and drive to Brooklyn, N.Y., where they slaughtered sheep by a certain technique which permits the enzymes in the brain to be preserved. They removed these brains, put them in the back of the station wagon and drove back to Boston. The night they arrived they stayed up all night processing these brains to get very small amounts of these important enzymes which are useful in their research.

Since this research resource has been established, obviously this is not necessary either for our department of biochemistry or other departments in the area to perform this maneuver.

A second example is the primate centers which have been established in a variety of areas on the west coast, the East, the Middle West, and so on. These provide primates for experimentation. These are definitely of regional value, and I think this is the kind of thing that the bill speaks to, of providing regional research services to investigators in their own institutions.

The CHAIRMAN. I am glad to have that clarification, which seems to me might be a good thing.

I should think if that is what is intended the bill ought to say it. I would like to think about it.

Dr. BERSON. If I may add one other thought here, it is my understanding that the plan is to make very modest beginnings, or extend the beginnings already made with the primate centers in this field.

But one example of an area for research that would be very important for the Nation as a whole is research in the aging process, geriatrics. We face enormous problems of all sorts—social, economic, medical—in an aging population.

The CHAIRMAN. I am beginning to get interested in that.

Dr. BERSON. I think you can make a good case; that it would be in the Nation's interest to have at least one place where men with the right interest, but competence in a variety of disciplines, came together for research in this broad area.

In my own opinion, we don't need many of those, but it would be very useful if we had at least one. I think there are a few other areas in which, from a national need for more knowledge, you could justify a research center in that area, but not Tufts, or Arkansas or Alabama is going to have the resources to do this. They may have

the brains, but there will have to be careful study as to whether there should be such a center and, if so, where? But I think it is justified on a national basis; that this authority in this bill will be useful.

The CHAIRMAN. Thank you, Doctor.

Mr. GILLIGAN. Mr. Chairman—

The CHAIRMAN. Mr. Gilligan?

Mr. GILLIGAN. On this point, and I know the question was not put to me, in Mr. Dempsey's statement the other day on page 7, he pointed to what the Department evidently thinks is the use of a regional center. One use of a center is not only the research in the narrow field of medicine, but the broader field of atmospheric and water contaminants. And in another sentence he refers to bringing to bear the diverse capabilities resident in schools of medicine, pharmacy, agriculture, and veterinary medicine in a new, combined scientific attack.

I would think that there are probably areas of the country where you have different atmospheric conditions and also have different faculties available for regional problems in the Southwest, the Northeast, which are more than just a general problem, but a very specific problem in the area. That seems to be one of the things that they are driving at.

The CHAIRMAN. The gentleman from Illinois.

Mr. SPRINGER. I have no further questions, Mr. Chairman.

The CHAIRMAN. The gentleman from California.

Mr. VAN DEERLIN. You have indicated that the present ratio of physicians to populations is about 1.4 per thousand. What, in your thinking, would be the desirable ratio?

Dr. BERSON. I don't think any ratio could be stated that everyone would agree to. We have talked for several years about maintaining the ratio that has existed for several decades in this century, and that is in the range of 135 to 140.

In my own opinion, we are short of doctors and a somewhat higher ratio would be indicated. But I don't know how I could pinpoint that and be sure that many people would agree that it is not 140, but it is 160. I think a generalization that we are short of doctors I can defend, but I don't think I could defend a specific number.

Mr. VAN DEERLIN. Would the true ratio be more meaningfully reflected if we were to measure the ratio of general practitioners?

Dr. BERSON. I don't think so. But the ratio of doctors to population is really a very partial expression of what is important. The Public Health Service keeps data on at least 32 categories of trained workers in the health field, and how well supplied a community or region or institution is, with the whole gamut of trained people it needs, is what is important.

Conceivably, you could have more than enough doctors and too few nurses, and you would be in trouble, or the other way around. So this is a very complex formula. I don't think it helps much to measure the number of general practitioners, partially because it is very hard to define, what a practitioner is, for example, many men who would say that they are surgeons are doing a good bit of what other people say a family physician does.

But it is pretty hard to be precise enough about that to have figures for a State, even, that mean very much.

Mr. VAN DEERLIN. Of course, the impression drawn by most persons in need of medical attention would be based not on the mathematical ratio, but the time that they have to wait for an appointment.

Dr. BERSON. That is right.

Mr. VAN DEERLIN. I should imagine that the area in which we live here is not unusually shy in the ratio of doctors to patients, and yet the waiting period I have found is very considerable.

Dr. BERSON. Yes. It is general observations of that sort that I think support the position that we need more doctors. But I don't know how you can translate that to a specific number of doctors that we need.

Mr. VAN DEERLIN. Except the police officer associations tell us how many police we need per 1,000 population, and the education associations tell us what the ideal ratio between teacher and the number of children in a classroom is. Whatever the desirable ratio might be in the medical field, we know it is higher than what we have.

Dr. WOLF. It may interest you, sir; that the ratio of general practitioners per unit of population in the State of Vermont is the same as that of Washington, D.C.

Mr. VAN DEERLIN. In the State of what?

Dr. WOLF. In the State of Vermont, the ratio of general practitioners per unit of population is the same as Washington, D.C.

I suggest that the practice of medicine in Washington, D.C. for a general practitioner is quite different than it is in the State of Vermont.

Mr. VAN DEERLIN. I imagine that might be so. I have no information on which to defend or assail the ratio in Vermont.

Thank you, Mr. Chairman.

The CHAIRMAN. In that regard, I believe during the course of the hearings 2 years ago there was some discussion about an average goal that was about 139, I believe, to every 100,000.

Dr. BERSON. I am not sure what you are referring to, sir.

The CHAIRMAN. During the course of the hearings on the Health Professional Assistance Act 2 years ago the committee considered the ratio of doctors to population. I know you cannot use it as a precise guide to meeting the problem, but taking an average situation into consideration, and considering the different kinds of practices, and the conditions, as mentioned, between Vermont and Washington, D.C., it seems to me that there was some discussion of a national average. I think it was at that time, or whatever it was, that the goal was to increase or at least maintain, the ratio.

Mr. VAN DEERLIN. Mr. Chairman, whose goal would that be?

The CHAIRMAN. That is the objective that we have—meeting the needs of the general public.

Mr. Younger?

Mr. YOUNGER. No questions.

The CHAIRMAN. Mr. Pickle.

Mr. PICKLE. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. Pursuing this, the research center question that was brought up, as I understand it, your suggestion is that there are areas of research, for example with the aging, and the need may exist.

Do you have in mind that there should be research centers relative to aging in geographic areas all over the country, or just a limited number?

Dr. BERSON. No, sir. I think you can make the case for two kinds of research centers not now provided for, and that this authority might lead to their development. One is the sort of research resources, such as the primate centers, the enzyme center Dr. Wolf referred to, and others, that would clearly be useful on a regional basis.

The other you might think of, I believe, as other categories of problems, such as aging. I wouldn't see any regional relation there. I think it would be in the national interest if there were a sophisticated and competent center trying to advance knowledge in that, but in any major city, on any major campus, would seem a satisfactory location to me.

Mr. NELSEN. It seems to me that your observation is not in disagreement with Dr. Appel. I think it is a matter of semantics in the interpretation of the language. In effect, when he says there are no regional bounds, for example, in heart disease and cancer, he means each of those categories needs research attention to be made available to the rest of the country, and with reasonable attention to particular parts of the country. It seems to me there is a fair amount of uniformity between your thinking and that of Dr. Appel, really. I think it is a matter of interpretation.

Dr. BERSON. I have assumed that the Public Health Service intends to go into this in a very modest way with very careful study. But they are requesting the authority to do so, which seems to me a sound authority for them to have.

Mr. NELSEN. I want to thank you for your testimony. It seems to me the last time I saw you was in Alabama. Thank you.

The CHAIRMAN. Mr. Huot.

Mr. HUOT. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Harvey?

Mr. HARVEY. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Gilligan?

Mr. GILLIGAN. No questions. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Carter?

Mr. CARTER. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Farnsley?

Mr. FARNSLEY. Thank you, Mr. Chairman.

Give me an idea about the ratio of technicians to doctors. Is this a matter of importance or discussion?

Dr. BERSON. It is not a matter that is very commonly discussed on a national basis or one that I am extremely familiar with. In many instances the number of technicians in relation to the work to be done is of vital importance.

I am not familiar with translating that to technicians' workload-doctor ratios.

Mr. FARNSLEY. Is there a future in giving the general practitioner more helpful technicians or does he have enough? He is an expensive product to produce. Can his efficiency be improved?

Dr. BERSON. I think there is a bright future and, actually, one thing that all of us, even those who have been working in the field a long time, need to pay a lot more attention to is the tremendous increase in the number of trained people in these many categories of workers, which has been enormously beneficial. Therefore, our people are getting better medical care, but we have not been very thorough in our keeping up with this in a quantitative sense.

Every doctor you talk to will agree that there is a great shortage of nurses. But very few of them are very familiar with how many nurses are being trained in their own community or other such quantitative approaches to the problem.

Mr. FARNSLEY. Is there a shortage of other technicians who might be of help to a doctor?

Dr. BERSON. Yes. I think there is an opportunity for the development of additional categories of workers. Some are emerging currently.

Mr. FARNSLEY. I have one more question. Could one doctor properly serve more people if he had more technical help? I am not trying to put words in your mouth, but I want to know.

Dr. BERSON. In a great many instances, it seems to me, and this is my opinion, not the association's, that doctors developing a staff of secretaries, nurses, technicians, have greatly increased their effectiveness, and it seems to me that at least many, many times, when doctors have gone together to form a group, and they have had facilities and personnel to help them, this has been an enormous benefit to their patients.

There have been a few groups that have fallen apart after they were put together, and there have been some doctors who developed such big staffs that the overhead was a burden and they have cut it back down, but in general I think that a doctor's ability to use technicians and nurses and other helpers, and to work shoulder to shoulder with his colleagues, greatly increases his effectiveness.

Mr. FARNSLEY. Thank you so much.

That is all, Mr. Chairman.

The CHAIRMAN. Doctor Berson and Dr. Wolf, we want to thank you for your testimony and the information which you have given to the committee on this important program. We are glad to have you back with us.

Dr. BERSON. Thank you.

Dr. WOLF. Thank you for the opportunity.

(Dr. Berson later submitted the following supplemental statement:)

SUPPLEMENT TO THE STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INCREASES IN THE NUMBER OF STUDENTS ENTERING THE FIRST YEAR OF MEDICAL SCHOOLS IN THE UNITED STATES 1957 THROUGH 1963

In the 7 years between 1957 and 1963 there was an increase in the number of students entering medical schools in the United States from 8,030 to 8,842. In 1957 there were 85 medical schools and in 1963 the number had risen to 87. The number of entering students in each year is shown in the following table:

Year:	Number
1957-58.....	8, 030
1958-59.....	8, 128
1959-60.....	8, 173
1960-61.....	8, 298
1961-62.....	8, 483
1962-63.....	8, 642
1963-64.....	8, 842

MEDICAL SCHOOL PLANS FOR CONSTRUCTING RESEARCH FACILITIES

Estimated costs of construction

To help support the legislation at congressional committee hearings during the winter of 1962-63, the Association of American Medical Colleges and the American Medical Association conducted a joint survey of U.S. medical schools to get an

up-to-date estimate of construction needs through 1973. The figures which follow, shown in millions of dollars, were obtained January 1, 1963, from 86 medical schools and apply to two areas:

Con- struc- tion area	Activity	Educational facilities	Research facilities
1	New facilities.....	\$412.1	\$394.6
2	Modernization and rehabilitation.....	70.5	81.7
	Total.....	482.6	476.3

Matching funds

Further, the schools were asked what proportion of funds they might raise to match Federal grants. Most indicated they could raise up to 33 percent for educational and from 33 to 50 percent for research facilities. A few schools indicated they had no sources of matching funds.

Increased enrollment

Increase in first-year enrollment resulting from the increased construction varied by school from 5 to 100 percent, with an overall average of 20 to 25 percent, or an average estimated increase of approximately 2,000 first-year students.

Further, the schools estimated that if the Federal program is enacted, the graduate student enrollment could be more than doubled.

In the survey, the schools also were asked to project their financial needs by years. Table 1 shows their response.

TABLE 1.—*Estimated costs for future construction¹ for 86 U.S. medical schools 1963-73 by calendar years in which construction can be started*

[In thousands]		Research facilities
Year:		
1963.....		\$66, 060
1964.....		164, 560
1965.....		99, 735
1966.....		28, 573
1967.....		11, 100
1968.....		13, 040
1969.....		9, 702
No year given.....		83, 497
Total.....		476, 267

¹ Irrespective of sources of income.

NOTE.—Responses indicating 1962 as a starting date have been transferred to the 1963 grouping.

Since the legislation authorized Federal grants of up to 50 percent of the costs of this construction and since it is reasonable to expect the established medical schools to continue to receive something more than half of the research construction grant funds, the authorization of \$400 million for the next 5 years will fall somewhat short of meeting the currently visible needs of these institutions with no allowance for the new medical schools currently being developed.

PHYSICIAN-TO-POPULATION RATIO

Within the last 10 years a number of studies have dealt with the physician-to-population ratio to some extent. The Surgeon General's Consultant Group on Medical Education, headed by Mr. Frank Bane, reported in 1959 that the physician-to-population ratio had remained constant for the last 20 years at 141 physicians (doctors of medicine and osteopathy) per 100,000 people; stated the opinion that a minimal objective should be to keep the ratio from falling; and estimated that the number of graduates would have to increase from the 7,400 graduating in 1959 to 11,000 graduating in 1975. The consultant group also emphasized that many developments indicated that the demand for physicians' services may far exceed the minimal acceptable goal they described.

In 1962, your committee developed a very excellent record on this matter in its hearings on H.R. 4999, H.R. 8774, and H.R. 8833, January 23, 24, 25, 26, and 30, 1962.

The wide discussions that followed your hearings focused attention on the facts that accurately defining physician-to-population ratios and projecting them into the future is so complicated as to be quite inaccurate. In 1964, the National Health Resources Advisory Committee called a conference to consider the definitions to be used. It was agreed that, in the future, osteopaths, interns, and residents should be counted as "physicians" and that certain U.S. citizens overseas should be included as "population." If these new definitions are used it can be demonstrated that the Banc committee was right in reporting the physician-to-population ratio had been about constant up to that time. The best information available is that it continued to be about the same through 1963, the latest year for which information is available.

Three general points deserve special emphasis. The first is that the Public Law 88-129, "Health Professions Educational Assistance Act of 1963," did not go into effect early enough to influence directly the current size of the entering or graduating classes. The first loans and construction grants were approved in the fall of 1964 and will not apply to entering students until 1965 or later.

The second point is that such factors as the distribution of physicians by geographic area and type of practice, the availability of trained nurses and other allied professionals, and the effectiveness of organization for patient care are more important than the national physician-to-population ratio.

The third point is that this gross ratio is markedly affected by the number of foreign medical graduates. The number who come to this country for training as interns and residents has been substantial since World War II. The number who obtain licenses to practice and presumably become permanent residents has risen sharply in the last several years and is now about 1,600 each year.

The Association of American Medical Colleges is convinced it would be a mistake to rely very heavily on the foreign medical graduates as the future supply of physicians. They are needed badly in their own countries, the education many of them have had is not up to U.S. standards and so many things influence how many of them will obtain licenses each year, that the number to become available is quite unpredictable.

Finally, the Association of American Medical Colleges is in agreement with the expressed desire of your committee that the enrollments of medical schools be increased with the consequent increase in the number of graduates. The demand for opportunities to study medicine and the demand for the services of physicians continues to increase.

The CHAIRMAN. The next witness will be Dr. Isadore Tuerk.

May I say, Doctor, that you, coming from Baltimore, know very well your fellow Baltimore City townsman and distinguished and very able member of this committee, the Honorable Samuel Friedel.

Dr. TUEBK. Yes, sir.

The CHAIRMAN. Mr. Friedel is unable to be here this morning because of an important commitment which he had that took him out of the city. He wanted, for the record, to express his regrets that he could not be here to give you a personal welcome to the committee, and express his appreciation for the fine work you are doing in your very important responsibilities in Baltimore.

I also have a wire from the National Association of State Mental Health Directors, Mr. Harry Schnibbe, advising that you would present the testimony for the association on H.R. 2985.

The wire will go into the record at this point.

(The telegram referred to follows:)

WASHINGTON, D.C., February 27, 1965.

HON. OREN HARRIS,
Chairman, House Committee on Interstate Commerce,
House Office Building, Washington, D.C.:

Respectfully request permission to have Isadore Tuerk, M.D., commissioner, Department of Mental Hygiene, State of Maryland, appear on Friday, March 5, as witness representing National Association of State Mental Health Program Directors. Dr. Tuerk will present testimony on H.R. 2985, staffing funds for mental health centers.

HARRY SCHNIBBE,
National Association of State Mental Health Program Directors.

STATEMENT OF ISADORE TUERK, M.D., COMMISSIONER, MARYLAND DEPARTMENT OF MENTAL HYGIENE, ON BEHALF OF NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Dr. TUERK. Thank you, Mr. Chairman.

I, also, have a number of telegrams and statements from program directors and public officials from around the country that I would like, with your permission, to submit for the record.

The CHAIRMAN. Let them be included in the record at this point.

(The telegrams referred to follow:)

COLUMBIA, S.C., March 4, 1965.

Dr. ISADORE TUERK,

National Association Health Program Directors, Washington, D.C.:

I would like to add to the expressions of support made by the South Carolina Legislative Governors Committee on Mental Health and Mental Institutions, my own support for H.R. 2985.

Thank you very much for your consideration of this viewpoint.

DONALD RUSSELL, *Governor of South Carolina.*

COLUMBIA, S.C., March 3, 1965.

Dr. ISADORE TUERK,

National Association Mental Health Program Directors, Washington, D.C.:

In making your presentation supporting H. R. 2985, indicate backing of members of South Carolina Legislative Governor's Committee on Mental Health and Mental Institutions, standing committee of six legislators and three citizens which has studied and promoted mental health movement since 1958. Although several existing mental health clinics are in position to expand physical facilities and/or programs, budgetary outlook for initial staffing is grossly inadequate to provide services to people in need.

State Senator EARLE E. MORRIS, Jr., *Chairman.*

COVINGTON, LA., March 4, 1965.

ISADORE TUERK, MD.,

Commissioner, Department of Mental Hygiene, National Association of State Mental Health Programs, Washington, D.C.:

We, the undersigned, actively involved in the mental health program in the State of Louisiana wish to express our interest in and hope for favorable action on bill H.R. 2985. In this State a great need exists for community mental health treatment centers to provide essential care and treatment for the mentally ill. Such treatment cannot be provided with assurance in all areas without Federal aid to assist the communities in initial cost required to staff such centers with professional and technical personnel. Not only does the need exist, but there is a widespread community interest in such treatment centers.

Southeast Louisiana Hospital, Mandeville, La.: Dr. Thomas Fulmer;
Dr. Richard Johnson; Dr. Hervey Mead; Dr. Kenneth Ragan;
Dr. William Bloom; Dr. Lathan Crandall; Dr. Suzanne Sears;
Dr. Donald Gallant; Dr. Allen Johnstone; Dr. Daniel Spreke;
Dr. Carolyn Kitehin; Dr. Thomasina Blissard.

HOUMA, LA., March 4, 1965.

V. TERREL DAVIS, M.D.,

President, National Association of State Mental Health Program, Washington, D.C.

DEAR DR. DAVIS: The Regional Planning Council for Mental Health, region 8, representing a cross section of leaders in medical and other health professions, as well as representatives of local governing bodies, has authorized me to convey their unanimous support of H.R. 2985. The council feels these funds are imperative to provide adequate services to needy citizens. They ask for favorable committee action and speedy passage of this important legislation.

Respectfully,

MICHAEL SEGURA,
Chairman, Regional Planning Council Region.

BATON ROUGE, LA., March 3, 1965.

ISADORE TUERK, M.D.,
National Association of State Mental Health Program Directors:

Urgent need in Louisiana for Federal financial support to pay a portion of the costs of compensation of professional and technical personnel for the initial operation of comprehensive mental health centers. Two comprehensive centers activated in 1963 are only partially staffed, two new community centers build in 1964 are vacant. One new comprehensive center under construction will be completed this spring, and five public and one private comprehensive centers are planned for construction in 1966. Full implementation of elements of comprehensive services in the existing centers and new centers will be drastically curtailed or nonexistent without temporary Federal support for operational expenses. This initial Federal support will enable Louisiana to demonstrate the needs and values to the communities for comprehensive mental health services. Passage of the Harris bill will be an economic savings to the taxpayers of this country and a measure to help prevent serious psychiatric disorders.

JOHN PAUL PRATT, M.D.,
Commission of Mental Health, Louisiana State Department of Hospitals.

RALEIGH, N.C., March 4, 1965.

Dr. ISADORE TUERK,
Washington, D.C.:

The North Carolina Department of Mental Health strongly endorses H.R. 2985 providing Federal funds for staffing of mental health centers, Federal funds for planning program and for construction have stimulated communities toward maximum involvement. Without Federal assistance for staffing, local program will not develop or will be unduly delayed and grossly inadequate. Federal support will provide a firm base which is urgently needed.

EUGENE A. HARGROVE, M.D.,
Commissioner, Department of Mental Health.

JEFFERSON CITY, Mo., March 3, 1965.

ISADORE TUERK, M.D.,
Washington, D.C.:

Be assured of any support we can give on your appearance before House Interstate Commerce Committee on H.R. 2985. Assistance for staffing mental health centers is of vital importance to developing new programs in our State.

GEORGE A. ULETT, M.D.,
Director, Division of Mental Diseases.

MADISON, WIS., March 3, 1965.

HARRY C. SCHNIBBE,
National Association State Mental Health Program Director, Washington, D.C.:

Telegram re H.R. 2985 signed by Governor sent to Dr. Yolles. Previous discussion with Governor's office had been around communication to Dr. Yolles and we did not want to switch signals on them.

L. J. GANSER, M.D.

BOISE, IDAHO, March 3, 1965.

HARRY C. SCHNIBBE,
*Executive Director, National Association of State Mental Health Directors,
Washington, D.C.:*

Idaho's geography and population patterns mitigates the effective immediate utilization of mental health center construction money. However, these same factors militate the urgent necessity of providing mental health services in the 38 counties now without any and of providing new services in those six counties which now have some rudimentary services.

Enactment of House bill 2985 would be of unestimable value to the orderly progression of community mental health services in Idaho. Bricks we need now; bricks we can purchase later.

TERRELL O. CARVER, M.D.,
Administrator of Health, Idaho Department of Health.

HARRISBURG, PA., March 3, 1965.

HARRY C. SCHNIBBE,
*Executive Director, National Association of State Mental Health Program Directors,
Washington, D.C.:*

Following is copy of message sent today to Hon. Oren Harris, chairman, House Committee on Interstate and Foreign commerce: "I urge your support of H.R. 2985/S. 513. Community mental health centers may be empty shells without this aid for staffing and operation."

ARLIN M. ADAMS,
Secretary, Department of Public Welfare, Commonwealth of Pennsylvania.

HARRISBURG, PA., March 3, 1965.

HARRY C. SCHNIBBE,
*Executive Director, National Association of State Mental Health Program Directors,
Washington, D.C.:*

Urge support of H.R. 2985/S. 513 providing aid in staffing mental health centers. This aid essential to operation of community facilities, without it centers may be empty monuments.

WILLIAM P. CAMP, M.D.,
*Commissioner of Mental Health, Department of
Public Welfare, Commonwealth of Pennsylvania.*

OLYMPIA, WASH., March 2, 1965.

ISADORE TUERK M.D.,
*National Association of State Mental Health Program Directors,
Washington, D.C.:*

Department institutions, State of Washington, having responsibilities ranging from institutions and community services for retarded and mentally ill, strongly supports H.R. 2985 re staffing for existing and newly developing community mental health centers. Experiences has shown financial task beyond States ability, and Federal funding must be forth coming if progress is to be made.

DR. GARRETT HEYNS,
Director of Institutions.

LAS VEGAS, N. MEX., March 2, 1965.

ISADORE TUERK M.D.,
*National Association of State Mental Health Program Directors,
Washington, D.C.:*

We feel manpower more important than buildings for success and effectiveness of the comprehensive mental health centers. We urge full support of H.R. 2985 to provide the staffing needed for the comprehensive mental health center programs.

DAN PALMER, M.D.,
Superintendent, New Mexico State Hospital, Las Vegas, N. Mex.

INDIANAPOLIS, IND., March 2, 1965.

DR. ISADORE TUERK,
*National Association of State Mental Health Program Directors,
Washington, D.C.:*

Federal financial support in meeting initial cost of professional and technical personnel for mental health centers is essential to develop comprehensive community mental health services. Federal funds will help furnish the manpower necessary to staff mental health centers. This is the program that can develop into the most important focus of treatment, re habilitation and preventive measures in our State and in all States. Approval of H.R. 2985 would be vital step forward in meeting our serious problem of mental illness. We in Indiana urge favorable action.

S. T. GINSBERG,
Indiana Mental Health Commissioner.

SANTA FE, N. MEX., March 1, 1965.

ISADORE TUERK, M.D.,
National Association of State Mental Health Program Directors,
Washington, D.C.:

Division of mental health in New Mexico in full support of efforts to gain funds for staffing of mental health centers.

EUGENE L. MARIANI, Ph. D.,
Program Director, Division of Mental Health, New Mexico Department of
Public Health.

LOUISVILLE, KY., March 1, 1965.

ISADORE TUERK, M.D.,
Commissioner, Maryland Department of Mental Hygiene, National Association of
State Mental Health Program Directors, Washington, D.C.:

The Kentucky Department of Mental Health strongly supports passage of House bill 2985. Although our department currently assists the operation or partial operation of community mental health programs, neither the State nor local communities can fully finance programs dictated by current mental health knowledge and needs. If Kentucky is to have adequate mental health programs for all of its citizens, it urgently needs additional financial health for staffing and operation of community mental health centers.

DANIEL S. TUTTLE,
Acting Commissioner, Kentucky Department of Mental Health.

ALBANY, N. Y., March 3, 1965.

ISADORE TUERK, M.D.
Commissioner, Department of Mental Hygiene,
Baltimore, Md.:

New York State Department of Mental Hygiene urges support for H.R. 2985. Our State pioneered the first Community Mental Health Services Act. The State and our units of local government are now spending more than \$40 million a year for the operation of community services, over and above our \$280 million budget for State-operated services. The rate of growth of our community programs cannot be sustained without Federal support for the staffing of community mental health and mental retardation services. Although we favor continuing participation by the Federal Government in the support of comprehensive mental health and mental retardation programs, we endorse H.R. 2985 as an important effort in this direction. This position reflects the recommendation of our regional and statewide planning committees composed of 800 professional and lay mental health and mental retardation leaders in New York State.

C. F. TERRENCE, M.D.,
Acting Commissioner, New York State Department of Mental Hygiene.

MARCH 5, 1965.

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS,
Washington, D.C.:

The Department of Mental Health and Corrections of the State of Maine, and the council of the Maine Medical Association supports the provisions for financial assistance for staffing as included in H.R. 1. The Department recognizes the impetus that such assistance in initial staffing would give to promote the establishment of comprehensive community mental health services. The medical association recognizes that such assistance would assist in displacing a portion of mental health care from fully State supported and controlled facilities to locally controlled and supported services, and to private care.

WILLIAM E. SCHUMACHER, M.D.,
Director of Mental Health and Chairman of Mental Health Committee of the
Maine Medical Association.

ST. PAUL, MINN., March 13, 1965.

Dr. ISADORE TUERK,
Washington, D.C.:

Comprehensive centers program ill-conceived. I do not support H.R. 2985.

Dr. DAVID VAIL,
Director, Division of Medical Services,
Minnesota Department of Public Welfare.

MARCH 8, 1965.

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS,
Washington, D.C.:

The Hawaii Department of Health is in favor of a Federal appropriation for assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers.

LEO BERNSTEIN, M.D.,
Director of Health, Mental Health Division, Hawaii Department of Health.

CHARLESTON, W. VA., March 4, 1965.

Dr. ISADORE TUERK,
Commissioner, Department of Mental Hygiene of Maryland, Washington, D.C.:

Public demand for community mental health and retardation centers is steadily mounting in West Virginia. Without qualified personnel for staffing such centers we are powerless to answer these demands. Mental health planning activities has created great interest in improving services for the mentally disabled and much local support has been promised. Plans for centers are being developed by several communities and we cannot afford to waste this interest and energy, yet wasted it will be without initial assistance in operation. We therefore urge passage of H.R. 2985.

Dr. MILDRED MITCHEL BATEMAN,
Director, West Virginia Department of Mental Health.

MARCH 3, 1965.

Re statement for hearing before Interstate Commerce Committee on H.R. 2985.

JOHN W. DEMPSEY,
Governor, State Capitol,
Commissioner's Office, Mental Health:

I represent before this body a State which welcomed with open arms the assistance which the 88th Congress provided to the States through passage of the Mental Health Centers Construction Act. I appeal to you today to help us further to do the job which we know we can do to treat and rehabilitate the growing numbers of mentally ill people who look to us for help. Traditionally, the care and treatment of the mentally ill has been the responsibility of the States; we do not seek to shift this responsibility but to share it. We seek to develop a team which together can provide adequate facilities and professional skills to return these unfortunate individuals to productive life. That team, in which the Federal, State and local government pool their tax resources, can turn the tax consumer back into a taxpayer.

Since the passage of the first Mental Health Act in 1946, the care and treatment of the mentally ill in our State hospitals has become ever more humane. Patients are well fed, well clothed, well housed. We will accept no less for our fellow citizens, but we seek to do more. The progress which science has made in recent years in the conquest of mental illness is of no less importance than the progress in the conquest of space; but we do not yet have the means to put this progress to work on behalf of the large number of troubled people who come to us for help.

The buildings which you are helping us to construct through Public Law 88-164 will be only as good as the people who staff them. Professional skills are expensive but only with them can we be effective in our goal of offering active, short-term treatment in the community. Present State tax structures, even in a relatively wealthy State as Connecticut is, cannot yet provide salaries which attract these skills into public practice; local tax bodies plead that the real estate taxes on

which they depend are hard put to meet the ever-increasing demands of education without the assumption of new burdens. Hopefully, one of the great results of the 2-year planning projects with which the Federal Government assisted the States in comprehensive planning of their mental health services will be to create regional facilities financed by the pooled resources of a number of contingent local communities. Hopefully, more and more of the cost of treatment for mental illness will be included in the insurance coverage with which our citizens meet their health needs. Business leaders are today having the foresight to see that it is economically productive to provide mental health services to their employees. Such a leader from my own State said before a group of his fellow executives recently, "If the cost of the solution is not cheap, the cost of neglect will be far greater."¹

You may be interested to know that the operating budget which I have requested for the coming biennium for the Department of Mental Health is in excess of \$61 million. Yet this is only enough to keep services at their present level. How, then, can local communities or nonprofit agencies which will be seeking construction funds for mental health centers, hope to operate high-level programs? The Federal Government, through its Congress, has today the opportunity of providing incentives to citizen groups and local governments to help its own members.

Let me give you an example of how this could work in my own State. We have in Connecticut a city of some 150,000 inhabitants, the second largest city in the State, which has at present no mental health facility other than a child guidance clinic and very limited adult outpatient clinic service. There is not one hospital bed in this city that is available for psychiatric treatment. The State hospital which serves it is 25 miles away; it admits approximately 600 patients a year from this city. There are very few psychiatric professionals in this city; there has been little to attract them. Tremendous effort on the part of the citizens has demonstrated an overwhelming need for a mental health center.

Grateful for the assistance which the Mental Health Construction Act has provided, I have asked this session of Connecticut's General Assembly to appropriate sufficient funds to allow us to build a comprehensive mental health center in this city which will offer a wide range of psychiatric services such as inpatient and outpatient care, day and night treatment, plus consultative services to such helping groups as the schools, the general practitioners, the clergy, public health nurses, family agencies. But who are the people who will staff this facility? Who will provide these urgently needed services? Surely we cannot rob the overburdened staffs of our State hospitals which want to be able to improve the treatment which they provide to the patients for which they will continue to have responsibility. We must attract into public service on a full- or part-time basis private psychiatric practitioners and young people now making career choices by offering them adequate compensation for their years of training. We cannot attract new people into the manpower pool with the present level of salaries which the States can offer, and we cannot continue to compete with each other for the scarce personnel in the present manpower pool. But we can educate the States and local communities and the citizen groups to the need for supporting this essential element of human welfare, and I appeal to you today to help us by sharing the initial costs of staffing.

The city which I described to you is but one of many urban centers in my State which is in need of mental health services. And my State is but one of 50 which presently undertakes the responsibility for providing these services. Give us the team leadership which will help us do our job better. In the final analysis, the citizen we serve is the responsibility of all of us.

The CHAIRMAN. You may proceed.

Dr. TUEBK. When the Congress passed the Community Mental Health Centers Act of 1963, it thereby embraced and endorsed a philosophy of treatment of the mentally ill. The Congress, in effect, has said it is good for the mentally ill to be treated in small centers, in their own communities, under intensive care.

But intensive care means a high ratio of staff to patients. More staff in public service means more money, and it means more money than the States and local communities can put up immediately. The

¹ Charles Zimmerman, before the Executives Club in Chicago in February.

directors of State mental health programs brought this warning to this same committee on Wednesday, July 11, 1963.

At that time, three of our representatives appeared before you and presented facts delineating the need for "seed money" from the Federal Government to help build professional staffs at community mental health centers. These men were Dr. George Jackson, of Arkansas; Dr. Harold Visotsky, of Illinois; and Dr. George Ulett, of Missouri.

Our witnesses before you in July of 1963 presented facts in support of a mental health program that would be decentralized, provide better patient treatment, closer to home, eventually self-supporting, with a reduction of Federal and State responsibility and money. This is still our hope.

All the facts marshaled in the 54 States and Territories support this hope. We still believe that with some "stimulation" from the Federal Government to help us get underway, we can be self-sufficient in the not-too-distant future. It is our hope that Federal assistance for staffing community mental health centers will stimulate the eventual operation of most centers not only by the States, but by local, private, nonprofit organizations. These local organizations today cannot afford to initiate and staff a mental health center. You can help guarantee the temporary nature of our position by helping the local communities staff their treatment centers. This is what H.R. 2985 will do.

STATE MENTAL HEALTH PROGRAMS TODAY

What is the current status of mental health programs in the States?

Our members are responsible today for the operation of 289 hospitals with 490,754 patients. For every 100,000 population in the United States last year we received 160 admissions into our hospitals. This is an increase from 110 in 1955.

Our old, custodial-type hospitals are gradually disappearing or being upgraded into more modern treatment centers. The hospital population is falling steadily. At the same time, admissions are increasing radically. We are treating more patients in shorter treatment periods, and our State hospital staffs are increasing in spite of unfavorable recruitment situations.

However, revamping the old hospital system is not the only answer. That is why, with admission loads relentlessly increasing as our population explodes, the State mental health program directors have steadfastly campaigned for decentralized, smaller treatment centers, where the sick can be treated swiftly and returned home.

The essential ingredient of rapid treatment of mental illness is high ratio of staff to patient. This must be accomplished in community mental health centers for them to be successful. Thus, the very treatment philosophy that this committee supported and framed into legislation in 1963 depends fundamentally upon staff. This is the issue you must come to grips with today.

Do you want the program initiated in 1963 to succeed? If it is to succeed, it must be reinforced by provisions for staffing and operating the decentralized, small center facilities.

HOW DOES STAFF MAKE A DIFFERENCE?

Every State can cite you examples of how high staff ratio to patients makes a radical difference in treatment of the sick, to say nothing of cost reduction. We cite one midwestern State as a typical example.

This State has 1 psychiatrist to 220 patients in a State hospital and 1 nurse to 90 patients. In that State the average stay of a patient is 255 days. The cost is \$5 per day, or \$1,275 per patient.

The same State is also operating a community mental health center, of a type envisioned by this committee when it approved the Community Health Centers Act of 1963. The community center sends patients home after an average stay of 32 days at a cost of \$24 per day, or \$768 per patient. The center is in part an intensive treatment hospital, and essential difference between it and the State hospital is staff.

The important point here is that by having more staff, by having a greater operating cost, we can reduce the average stay of the patient and thereby reduce the cost per patient.

The community center has 1 psychiatrist for 8 patients and 1 nurse for 5 patients. The possible net saving by treatment in a decentralized, local setting is \$507 and 223 sick-free, income-productive days per patient. But without staff the community center concept fails.

CAN STAFF BE HIRED?

Is there staff to be hired? Thanks to the many federally assisted training programs, more and more professionals are coming into our work. But it is not easy to attract them to public service in a mental hospital or community center. Between this year and 1970, only 5 years away, we will have 23,000 new, professionally trained persons entering the field of treatment of the mentally ill. That is professionally trained persons of a great variety—psychologists, psychiatrists, social workers, rehabilitation personnel, and so on.

These persons can be attracted to the "community center treatment concept" which this committee has espoused. They can be attracted because they are stimulated by new advances in treatment programs, and the centers provide such stimulation. The centers provide challenge. The centers provide visions. The centers provide opportunity for career development. Staff can be attracted to work in community mental health centers, but this takes a heavy initial infusion of money, more than the States, local communities, and private agencies can bear at the outset.

The graduates of training programs will remain in public service if they are given challenging jobs in exciting new programs at decent salary levels. We cannot be naive about the call of professionals to public services; the call must be sweetened by competitive salary rates, but given competitive salaries, the new professional will gladly turn to public service.

Last year in the State of South Carolina, every resident psychiatrist who finished training entered the service of the public. Not one man went into private psychiatric practice, and this in a State with lucrative opportunities as a result of a severe shortage of private practitioners. This can only be a tribute to the challenge inherent in the community centers program now being developed by Dr. William Hall, Commissioner of Mental Health for South Carolina.

Other psychiatrists who go into private practice devote part time to public service, to working in community hospitals, State mental health centers, and so on.

Funds are the answer. The community mental health center concept is exciting. Good staff will gravitate toward an exciting program. The States are just now in the process of developing the center concept. The final ingredient to attract and hold in public service new graduates is funds.

The States, the communities, the private, nonprofit organizations that will ultimately operate most of these centers need "seed money," money to stimulate and attract staff money to get the centers going, money which communities can gradually supplant once their centers have been catapulted into existence with a heavy transfusion of Federal money.

PHASED-OUT SUPPORT

The State mental health directors, studying the facts State by State, see the need for initial staffing support from the Federal Government in a program as described in H.R. 2985.

ASSURANCE OF FUNDS FOR NEW SERVICES IN OLD CENTERS

The directors of State mental health programs are happy that it is the intent of H.R. 2985 that Federal operating assistance will be available to existing centers that are starting new services to the mentally ill. In other words, it is our understanding that centers, other than "new" facilities, constructed with Public Law 88-164 money, will be qualified to receive aid under H.R. 2985. We are pleased that this bill will provide, as now written, that existing centers now in the process of adding new services to provide "comprehensive" and "intensive" treatment of the mentally ill will be eligible for Federal staffing assistance.

In summary, we state:

1. In the next 5 years over 20,000 new mental health professionals will become available for work among the mentally ill.
2. Many of these skilled people can be attracted to public service either in old or new community mental health centers.
3. They can be attracted by offering them public service with a challenge, in an exciting setting, at a competitive salary.
4. The States and communities and private, nonprofit groups cannot initially carry the financial load of operating the centers with the staff ratio necessary for effective treatment programs.
5. All of the facts marshaled by our State sources indicate that some Federal money used to stimulate the acquisition of new staff is necessary to get the centers program going.
6. It seems evident that once the Federal "seed money" takes effect and staffs grow and centers treat the sick and return them home, the local communities will be able to bear the financial burden of staffing and operating the centers.

Thus, the facts developed by the National Association of State Mental Health Program Directors point up an urgent need for the assistance that passage of H.R. 2985 would give to the development of services for the mentally ill at this critical point in history.

With your permission, I would like to make some comments concerning the situation in Maryland that I think has significance nationwide.

As an example of what is going on throughout the country, Maryland is energetically developing plans for community mental health centers. It has shifted the emphasis in its department of mental hygiene away from the public institutions for the care of the mentally ill to community mental health programs.

Early in 1963, all of the State mental hospitals in Maryland became regionalized and integrated; that is, each State mental hospital assumed responsibility for a specific region of the State. The goal is to enable State mental hospitals to coordinate and integrate their efforts with all of the various facilities in the regions served, to stimulate the development of community mental health centers and programs in the regions served, and to provide backup services in the regional State mental hospital.

The goal is to also transform, increasingly, each State mental hospital into a community mental health center for the area immediately adjacent to the hospital. The several parts of the State vary in their readiness to develop community mental centers. They vary in their readiness in terms of existing programs, and also in their financial capacities.

H.R. 2985 will permit some areas to expand their existing programs, to fulfill the requirements of a comprehensive community mental health center, without additional construction, and to establish new community mental health centers. In time, there will be new construction in other areas where initial operating expenses will be difficult to meet without Federal financial support.

It is anticipated that comprehensive community mental health centers developed in relationship with teaching hospitals and universities will provide an invaluable resource for not only serving the needs of the immediate community, but also developing trained, skilled professional personnel and also opportunities for research and evaluation of these vital new programs.

Over 300 communities in the country have already manifested overt interest in community mental health centers and the great majority feel they need financial assistance in initial implementation. The bill permits of support of program development of communities within the State where there may be great need for a program, but quite limited resources. This, I am sure, will be especially welcome in many States around the Nation.

Staffing is one of our serious needs in meeting the expanding community mental health programs, but skilled professional manpower to provide staffing will be one of the important products of certain community mental health centers.

The community mental health center is an attractive area to professional personnel for utilizing their abilities. Community mental health programs and community mental health centers will attract professional personnel. Salaries must be made available to exploit this opportunity. It is anticipated that a healthy spiral of improved services, comprehensive in nature, community centered, will develop, and along with this, an increasing number of professional personnel will appear to help man these centers. H.R. 2985 makes this possible.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much for your presentation on behalf of the national association, as well as your own remarks.

Mr. Van Deerlin?

Mr. VAN DEERLIN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Springer?

Mr. SPRINGER. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Pickle?

Mr. PICKLE. Dr. Tuerk, throughout the testimony of the last few days on this particular bill, most of those presenting testimony have been in favor of this bill, on the theory that local communities cannot finance it, but you need "seed money" to begin with. What makes you think that after a period of 4 to 5 years the local communities will be able to come in and meet the costs of staffing whereas they can't do it now?

Dr. TUERK. It has been our experience, and I have high hopes that this will be the situation again, that this program of the community mental health center, with its provision of a comprehensive, community-centered, continuous program, has excited the imagination, has responded to a sense of real need in the communities and on the State level.

We have found a great deal of enthusiastic support by the Governor, the legislature, and also by many local communities for this. It is my feeling that as this program develops, inspired in considerable part by Federal financial assistance, initially, phased out, that there will be a readiness on the part of the communities, on the part of the State, on the part of the patients who use these facilities through fees, on the part of insurance programs, to pick this up and to enable it to continue.

There has been some experience of federally supported programs which, when the Federal funds were no longer available, did continue as a result of local community support. One example of this is a program for alcoholism in Prince Georges County, in Maryland, where the Federal funds were used to develop a program that was found to be very valuable and the local community, through the county commissioners, made it possible for this to continue when Federal funds were no longer available.

Mr. PICKLE. You generally just have a feeling that the local communities would be able to meet it. You gave one example. I would have the feeling that for every 1 example you give me, I could give you 20 where they could not continue it. I don't know that it will be that bad in health services. We may see the time come under this where we use the same formula approach that we do under the Hill-Burton program, but I have a feeling that, the Lord willing, you and I, in 5 years, will be looking at each other across the table, with you asking for a continuation of this program.

I am looking for examples to see if the local communities can meet this and carry it by themselves. There is no point in prolonging it.

Dr. TUERK. I have no assurances of this.

Mr. PICKLE. You just have a feeling?

Dr. TUERK. I personally know of no commitments prior to the initiation of this program by communities for maintaining this. All I can say is, along the lines I have already stated, that I believe there will be a desire to do so, and that there will be as much support as is possible.

Mr. PICKLE. I will make this last question to you, then: Is it your feeling that 5 years from now you will expect the local communities to meet their part of this, to carry it on?

Dr. TUERK. The local communities, the State, and these other resources, too, the insurance groups, and so on.

Mr. PICKLE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Huot?

Mr. HUOT. No questions.

The CHAIRMAN. Mr. Harvey?

Mr. HARVEY. No questions.

The CHAIRMAN. Mr. Gilligan?

Mr. GILLIGAN. I have just one question, Doctor, that you may or may not be able to answer, or care to answer.

You made reference to a Midwestern State which had a different experience with their custodial centers and community health centers. Can you and would you care to identify the State?

Dr. TUERK. This was Missouri.

Mr. GILLIGAN. Thank you.

Dr. TUERK. We have had a very interesting similar experience in Maryland in that although our daily per capita has been going up, within the State hospitals, the duration of hospitalization has been going down and, therefore, the actual cost of treating a particular patient has been going down. In other words, the more energetic, the more effective the immediate care of a patient, in the long run the cost is decreased.

Mr. GILLIGAN. Doctor, I couldn't agree more with you that the answer is staff, whether we are speaking of the old-style custodial institution or the newer community health program; that without adequate staff we are down to human warehouses.

Dr. TUERK. That is right; yes.

Mr. GILLIGAN. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Carter?

Mr. CARTER. I just want to compliment the doctor on his excellent presentation.

Certainly I think that the plan which Maryland has is quite effective. It seems to me it has helped the State of Maryland a great deal. I just wish that other States had similar plans.

Dr. TUERK. Thank you, sir.

The CHAIRMAN. Mr. Farnsley?

Mr. FARNSLEY. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Callaway?

Mr. CALLAWAY. No questions, Mr. Chairman.

The CHAIRMAN. Doctor, thank you very much. We appreciate your appearance and your statement to the committee.

Dr. TUERK. Thank you.

The CHAIRMAN. Miss Lisbeth Bamberger will be the next witness.

Miss Bamberger, will you come forward? I believe you are the assistant director of the Department of Social Security of the AFL-CIO here in Washington.

STATEMENT OF MISS LISBETH BAMBERGER, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT, AFL-CIO (ACCOMPANIED BY JOHN BEIDLER, LEGISLATIVE REPRESENTATIVE, AFL-CIO)

MISS BAMBERGER. That is right, Mr. Chairman.

THE CHAIRMAN. We will be glad to have your statement.

MISS BAMBERGER. I am accompanied by Mr. Jack Beidler, legislative representative of the AFL-CIO.

THE CHAIRMAN. We are glad to have you, Mr. Beidler.

You may proceed.

MISS BAMBERGER. In the interest of conserving the time of the committee, Mr. Chairman, I will summarize the written statement that we have. Can my full statement be included in the record?

THE CHAIRMAN. It may be included in the record in full. You may proceed.

MISS BAMBERGER. We are here to appear in support of the four bills before you. We believe they will do much to achieve the objective that the President announced in his health message to the Congress, which the AFL-CIO has been supporting for many years, the objective that the advance of medical knowledge leave none behind, and that the best of health care be accessible to all Americans regardless of age, geography, or economic status.

All four bills before you now are crucial steps in eliminating these barriers that keep so many people from reaping the full benefits of modern medical care. We support the extension of the health research facilities program, of the immunization program, the project grants for community health services, and the continuation and we hope substantial expansion of the program of health services for migratory workers.

We noted the recommendation, which I believe was mentioned to your committee the other day, from the American Public Health Association, based on its study of the existing migrant health program, that appropriations should be at the level of at least \$10 million annually so that this program can provide more nearly comprehensive services to a larger number of migrant farm workers.

I would like to comment in greater detail on the two other bills, H.R. 2987, to assist group practice, and later on the staffing of mental health centers.

With regard to the program that would provide loans for the construction of group practice facilities, it is widely recognized that the greatest deficiency in our country's health services system lies in the way that medical services are organized. As the President's Commission on Health Needs of the Nation said:

The genius for organization so characteristic of American life in general is conspicuous in health services by its absence.

One of the most significant developments in coping with this problem of organization of medical care is the group practice of medicine. From the patient's point of view, group practice has turned out to be a marvelous thing. A family can obtain the entire scope of health services in one place. It can be assured of continuity and quality of care, along with economy.

The patient is cared for by doctors working in cooperation with each other in order to maintain his health rather than in competition for his

fee. The encouragement of group practice that would be provided by the enactment of H.R. 2987 would, we believe, be extremely beneficial.

We are particularly impressed with the potential inherent in the combination of group practice with comprehensive prepayment. On the basis of our experience in collectively bargained health insurance, we have found that the combination of these two things, comprehensive prepayment with group practice, leads to a much more effective use of funds, of negotiated health and welfare dollars, of funds expended by individuals on their own behalf, and of Government funds as well.

When these two things are combined, we find that economic barriers to needed care are removed; we find that all important health services can be made available, including care in the doctor's office, the medical center, and the home; we find that care can be directed toward the prevention and early detection of illness; we find that the amount of hospitalization can be radically reduced because people need not go into the hospital in order to collect benefits; and the care is available at a time when the disease may be in such an early stage that extensive hospitalization can be entirely prevented. We have also found that under these plans combining group practice and prepayment, total family expenditures for health services amount to a lesser amount than under conventional insurance plans.

These plans have not spread as rapidly as many of us had hoped, and as, we believe, the adequate meeting of the health needs of millions of people would require. One of the reasons for this is that capital funds for the creation of the needed facilities have been extremely difficult to obtain.

We believe that the enactment of this bill, by making it easier to obtain financing for capital facilities, would result in the expansion of existing comprehensive prepayment programs, and, perhaps more importantly, would result in the formation of such plans where they do not now exist.

We have supported the objectives of this bill for many years as consumers of medical care, and we have also had the support in our efforts to get this kind of legislation enacted of an impressive array of experts in the medical care field. I have already mentioned the President's Commission on Health Needs of the Nation, which recommended as long ago as 1952 that Federal loans be made to local organizations desiring to institute prepayment plans associated with group practice.

The Rockefeller Brothers' fund recommended the enactment of legislation of this kind. The American Public Health Association, as well, recommended it. Hubert Humphrey was one of the earliest sponsors of the predecessor bill to H.R. 2987. Some 5 years ago the Honorable Arthur S. Fleming, who was then Secretary of Health, Education, and Welfare under President Eisenhower, also urged the enactment of Federal assistance to physicians in group practice and to prepayment plans associated with group practice.

The Group Health Association of America, from whom I believe you will be hearing later today, and the AFL-CIO, who have advocated legislation of this kind for many years on behalf of the consumers of medical care, have found most welcome the enthusiastic support of these major professional organizations and experts on the medical care scene.

We have been most grateful for the leadership for the enactment of this legislation that has been provided by three administrations, and by the sponsors of this bill, Chairman Harris and Senator Lister Hill.

We do very much hope that this committee will promptly and favorably act to convert the very widespread public support for this measure, and the clear need for it, into long overdue law.

With regard to Federal assistance for the staffing of mental health centers, as proposed in H.R. 2985, there are very few health problems that are as pervasive and of as serious consequences to workers and their families as are the problems associated with mental illness.

Our interest in the labor movement in the development of community mental health services is considerably sharpened by our awareness that existing mental health programs meet the needs of lower income families far less adequately than those of upper-income families. Many of the treatment methods that seem to offer the greatest hope of recovery are substantially more available to well-to-do than to low-income patients.

State mental hospitals, many of which, as this committee knows, are still appallingly inadequate, have functioned as the major source of care for the mentally ill of the lower classes. Community mental health services have, by and large, been used by those who are financially better off.

We have some figures indicating the extent to which this is true. A study in New York of psychotic patients receiving treatment showed that 50 percent of those in the upper socio-economic group were treated on an out-patient basis, and 50 percent were hospitalized. Among lower class psychotics, only 10 percent were receiving out-patient care, while 90 percent were hospitalized.

Another study, and this one was done in Connecticut, found that among persons receiving treatment and classified as neurotics, one-third of the patients in the lower socio-economic group were hospitalized; not a single neurotic patient in the upper classes was hospitalized.

Outpatient care of mental illness, as these figures show, in a community setting, has, with some notable exceptions, simply not been available to working people and to the poor. You can, therefore, understand our enthusiasm when President Kennedy presented, in 1963, his bold new approach to combating mental illness based on the creation of comprehensive community mental health centers which would be built and staffed with Federal financial assistance.

You can also imagine our disappointment when the Community Mental Health Centers Act of 1963 was passed without provision for Federal assistance for the staffing of these centers.

Representatives of labor have worked diligently in the last several years, and particularly the last year or so, in cooperation with other groups in the community and mental health professionals in the planning of new community mental health services. In the process, we have become increasingly determined that recent advances in the treatment of mental illness, including such things as day care and night care, brief psychotherapy, emergency walk-in clinics, and so on, that all of these must be available to all who may require such services, regardless of social and financial circumstances and backgrounds.

We have also come to the conclusion that the only really effective way that this can be done is through the community health centers. We are absolutely convinced that without the enactment of H.R. 2985 providing Federal funds for the operation of these centers, the

promise of 1963 mental health legislation will turn out to have been empty, indeed.

This statement is considerably more than rhetoric, because we know that the needs of working people and their families for community mental health care simply will not be met unless new and more appropriate kinds of services are developed and made available. We know also that no source of funds other than Federal financial support can be expected to bear the initial burden of this development.

There has been hope expressed about the use of insurance for financing outpatient psychiatric care. We believe that insurance has a role to play in this field, although it may be a limited one. But whatever that role turns out to be, it seems fairly certain that prepayment can be used most successfully where benefits are limited to services rendered through an organized setting. An organized setting can be provided by the community mental health centers. They will be able to provide this setting if they are given the initial impetus that Federal funds can provide, and that only Federal funds can provide.

We, therefore, conclude that favorable action on H.R. 2985 is an absolutely crucial step in the development of the kind of community health services that will meet the needs of all Americans.

May I thank the committee for the opportunity to appear before you, and urge most strongly, in conclusion, that you do act favorably on these four bills that you are considering today. They will be of great significance, we believe, in meeting the health needs of all Americans.

The CHAIRMAN. Thank you very much, Miss Bamberger, for your fine statement. We are glad to have the views of the AFL-CIO and your very fine manner of presentation.

(Miss Bamberger's full statement follows:)

STATEMENT OF LISBETH BAMBERGER, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS, MARCH 5, 1965

Mr. Chairman, my name is Lisbeth Bamberger. I am assistant director of the Department of Social Security of the AFL-CIO. I am accompanied by John Beidler, legislative representative of the AFL-CIO. We are appearing in support of the four bills being considered by this committee.

For over two decades the AFL-CIO has sought actively to remove the barriers that stand between many Americans and the medical care they need. We therefore endorsed with great enthusiasm the objectives enunciated by President Johnson when he transmitted his health program to the Congress: that the advance of medical knowledge leave none behind, and that the best of health care be accessible to all Americans, regardless of age or geography or economic status.

The AFL-CIO Executive Council, in outlining its 1965 legislative goals before this session of Congress opened, declared:

"The ever-accelerating advances in medical science hold forth the promise of long life and good health to a degree never before imagined.

"The benefits of this astonishing progress must be made available to all Americans. But this cannot be brought about without legislative action."

The four bills before your committee now are crucial steps in eliminating some of the barriers that keep many of the men, women, and children of this Nation from reaping the full benefits of the best of medical care.

I should like to comment very briefly on H.R. 2984, the health research facilities amendments, and H.R. 2986, the community health services extension amendments.

We support the extension and expansion of the health research facilities program, as proposed in H.R. 2984, in recognition of the need for such Federal support if the opportunities for progress in pushing back the frontiers of medical and scientific knowledge are to be realized.

We support the extension and expansion of each of the programs contained in H.R. 2986. The enactment of this bill would contribute substantially to improving the health of many Americans.

Our support for the extension of the immunization program is based on the simple premise that suffering and death from polio, diphtheria, whooping cough, tetanus, and other infectious diseases—including measles—cannot, in this affluent Nation, be allowed to coexist with the scientific techniques which could prevent them.

We favor the extension of project grants for community health services in the hope that these will provide the necessary financial backing for much needed innovation in the delivery of community health services.

We also endorse the continuation and substantial expansion of the program providing funds for health services to migratory workers. The present program has demonstrated both the need and the potential effectiveness of a vastly larger program than is now underway. We have noted the recommendation of the American Public Health Association, based on its intensive study of the program, that appropriations at the level of at least \$10 million annually will be necessary to reach a larger number of migrant workers, and to provide more nearly comprehensive services—including hospital care where necessary.

Migratory workers are among our most deprived citizens. They urgently need and richly deserve our prompt and full attention to their health needs.

H.R. 2987—LOANS TO GROUP PRACTICE FACILITIES

It is widely recognized that the greatest deficiency in this country's health services system lies in the way that medical services are organized and delivered. As the President's Commission on the Health Needs of the Nation said in its landmark report more than a decade ago.

"The genius for organization, so characteristic of American life in general, is conspicuous in health services by its absence."

Better organization is the key to making the benefits of medical research and modern medical care more readily accessible to all.

Among the most promising developments in the improved organization of medical care is the group practice of medicine. Group practice, to quote the President's Commission once more:

"Not only can be an efficient, economical method of organizing health service but also may provide an invaluable setting for continued improvement in the quality of care * * *."

From the patient's point of view, group practice is a great boon. The family can obtain the entire spectrum of health services in one place. Continuity and quality of care are maximized—along with economy. The patient is cared for by doctors working in cooperation with each other to maintain his health, rather than in competition for his fee.

The encouragement of group practice provided by H.R. 2987 would, therefore, be most beneficial.

We are particularly impressed with the results where group practice has been combined with prepayment. Vastly more effective use of funds spent on personal medical care—whether by individuals on their own behalf, by governments, or through negotiated health and welfare funds—can be expected to follow a significant expansion of comprehensive direct-service health plans—which are the product of a combination of group practice and prepayment. This development would also be encouraged by the enactment of this bill.

Our interest in the expansion of direct-service health plans is based on our many years' experience with collectively bargained health insurance.

During the first few years that unions were negotiating for health coverage the problem seemed to be a fairly simple one. It seemed that if only the money to pay for care could be found, then the medical care problem would be solved.

In this first stage we were concentrating on getting employer participation in the financing of a health insurance plan—any health insurance plan.

We had to rely primarily upon the traditional patterns of health insurance available through Blue Cross, Blue Shield, and commercial insurance. The protection these programs have afforded is one of the impressive accomplishments of collective bargaining. However, experience has demonstrated the prevailing kinds of plans have serious deficiencies: (1) they make no provision to assure high quality of medical care, (2) they typically do not provide benefits for early diagnosis and prevention of disease, (3) they have proven incapable to controlling the rapid rise in the cost of medical services, and in fact, have to some extent contributed to the spiralling of costs, and (4) they have met but a fraction of the medical care expenditures of the average family.

In contrast, those health programs under which comprehensive benefits are provided by a team of physicians representing many specialties, along with auxiliary personnel, organized on a rational basis in group practice, have amply demonstrated their value. Economic barriers to needed care are removed through the provision of comprehensive payments. All important health services are made available including care in the doctor's office, the medical center, and the home. Care is directed toward the prevention and early detection of illness. It has been found that the amount of hospitalization is radically reduced for members of most comprehensive plans because they need not go to the hospital to collect benefits, and because there is more preventive care to catch and control disease before it becomes serious enough to result in a hospitalized illness. These plans have been able to organize the provision of high-quality services so well that the total family expenditures for health services are actually less under such plans than under conventional insurance programs.

Despite these advantages, the growth of comprehensive direct service plans has been slow. One reason for this is the difficulty of financing the required physical facilities.

Capital funds for the creation of needed facilities are currently extremely difficult to obtain.

Yet the proper physical facilities are essential to the economic operation of these plans, to the rendering of high-quality care and to the recruitment of highly qualified medical and related personnel.

By making such funds more available, the loan and loan guarantee program contained in H.R. 2987 would assist existing comprehensive plans to expand. More important, this program would stimulate the formation of such plans where they do not now exist, thus making well organized, high quality, economical medical care more widely available. The expansion of these plans is possibly our best hope in the search to find a way to bring the benefits of modern medical care to vastly greater numbers of the American people.

The objectives of H.R. 2987—to encourage the development of group practice, and of group practice coupled with prepayment—are supported not only by the experience of our members as consumers of medical care, but by an impressively wide array of those who have devoted time and energy to an analysis of the problem of delivering medical care services.

The President's Commission on the Health Needs of the Nation, which I have already mentioned, recommended in 1952 that "Federal loans be made to local organizations desiring to institute prepayment plans associated with group practice, for the purpose of encouraging the establishment of group practice facilities."

The Rockefeller Brothers Fund, in a report issued in 1958, advocated that "this group practice prepayment approach" be adopted by more communities.

The American Public Health Association, by unanimous action of its governing council, in 1959 endorsed the principle of long-term Federal loans to nonprofit prepaid group practice plans.

Since the day, more than a decade ago, that the then Senator from Minnesota, Hubert Humphrey, sponsored the first predecessor bill to H.R. 2987, there has been a growing consensus supporting the enactment of a program of Federal assistance to group practice and group practice prepayment.

A little more than 5 years ago, the Honorable Arthur S. Fleming, then Secretary of Health, Education, and Welfare, under President Eisenhower, urged the enactment of Federal assistance to physicians in group practice and to prepayment plans associated with group practice in order to "stimulate the growth of private voluntary systems providing comprehensive coverage of the cost of medical care."

Every presidential health message to the Congress since 1962 has highlighted the need for Federal assistance to group practice and to group practice associated with prepayment.

The Group Health Association of America and the AFL-CIO, who have advocated legislation of this kind for many, many years on behalf of the consumers of medical care, have found most welcome the enthusiastic support of major professional organizations and experts on the medical care scene. We have been most grateful for the leadership applied to the enactment of this legislation provided by three administrations, and by the sponsors of this bill, Chairman Harris and Senator Lister Hill. We earnestly hope that this committee will promptly and favorably act to convert the wide public support and clear need for this bill into long overdue law.

H.R. 2985—STAFFING COMMUNITY MENTAL HEALTH CENTERS

There are few health problems that are as pervasive and of as serious consequence to workers and their families as are the problems associated with mental illness. The labor movement is profoundly concerned with these problems. And we are hopeful because we believe that current developments—including scientific and medical breakthroughs and a heightened public awareness and commitment—make possible great advances in the prevention of mental illness, and in the care, treatment, and rehabilitation of the mentally ill.

As in many other areas where high-quality services essential to individuals and to social well being are not available to everyone in the Nation, the labor movement—as an organized group of consumers—is using and intends to use its influence to make better mental health care more widely available. In doing so we speak for our own members and their families, and for others as well who may be unemployed, unorganized and with low incomes, whose needs are not adequately met, and whose voice often remains unheard.

Our interest in the development of new community mental health services is sharpened by our awareness that existing mental health programs meet the needs of lower income families far less adequately than those of upper income families.

Many of the treatment methods that seem to offer the greatest hope of recovery are substantially more available to well-to-do than to low-income patients. State hospitals, many of which are still appallingly inadequate, have functioned as the major source of care for the mentally ill of the lower classes; community mental health services have been used largely by those who are financially better off. A study in New York of psychotic patients receiving treatment, showed that 50 percent of those in the upper socioeconomic group were treated on an outpatient basis and 50 percent were hospitalized; while among lower class psychotics, only 10 percent were receiving outpatient care and 90 percent were hospitalized.¹ Another study—this one in Connecticut—found that among persons receiving treatment and classified as neurotics, one-third of the patients in the lowest socioeconomic group were hospitalized, while not a single neurotic patient in the upper classes was hospitalized.²

Outpatient care of mental illness in a community setting has, with notable exceptions, simply not been available to working people and the poor.

You can understand our enthusiasm when President Kennedy presented, in 1963, his "bold new approach" to mental illness, based on the creation of comprehensive community mental health centers, built and staffed with Federal financial assistance.

Representatives of labor worked diligently, in cooperation with other groups in the community and with mental health professionals, in the planning of expanded mental health services throughout the country. In the process we have become increasingly aware that scientific knowledge and understanding about the prevention and treatment of mental illness have enormously increased over recent years, and we have become increasingly determined that the recent advances in the treatment of mental illness, including day care and night care, brief psychotherapy, emergency walk-in clinics, family evaluation and treatment, treatment at the time and place of crisis, and relatively brief hospitalizations—that all of these must be made available to all who may require such services, regardless of social or financial circumstances and background.

We believe that this can most effectively be done through comprehensive community mental health centers. When the Congress enacted the Mental Health Centers Act of 1963 without authorizing funds for the staffing of these centers, our disappointment was acute. Today we are convinced that without the enactment of H.R. 2985, providing Federal funds for the operation of community mental health centers, the promise of the 1963 mental health legislation will turn out to have been empty indeed.

This statement is more than rhetoric. We know that the needs of working people and their families for community mental health care will not be met unless new and more appropriate kinds of services are developed and made available. No source of funds other than the Federal Government can be expected to bear the initial burden of this development.

There has been much hope expressed about the potentialities of private voluntary insurance for financing psychiatric care. We believe that insurance has a role to play in this field, although it may be a limited one.

¹ Leo Srole, and Thomas Langner, et al., "Mental Health in the Metropolis," 1962.

² Hollingshead, August B. and Frederick C. Redlich, "Social Class and Mental Illness," New York, 1958.

Whatever that role may turn out to be, it seems clear that prepayment can be used most successfully where benefits are limited to services rendered through an organized setting. Community mental health centers can provide this setting. They will be able to do so if they are given the initial impetus that only Federal funds can provide.

We therefore conclude that favorable action on H.R. 2985 is an absolutely crucial step in the development of the kind of community mental health services that will meet the needs of all Americans.

The CHAIRMAN. Mr. Van Deerlin?

Mr. VAN DEERLIN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Springer?

Mr. SPRINGER. Miss Bamberger, back in 1954 I think the CIO appeared before us in behalf of the same thing, and we also had one from St. Louis which I think was not associated with the CIO, requesting the same thing when we were having hearings in 1953 on this matter. I have had no request of any kind in my area for any kind of assistance such as this.

What, for instance, do you visualize? I think labor has been a primary mover in this. What has been your need for this type of assistance?

Miss BAMBERGER. You are speaking of assistance to the group practice plans?

Mr. SPRINGER. Yes. That is what I had in mind.

Miss BAMBERGER. Mr. Springer, the labor movement has been supporting the development of group practice associated with prepayment, and a considerable number of our members, although it is a minority, are now beneficiaries of these plans. There is considerable evidence not only that the extension of such plans would benefit a larger number of our members, but that if these plans were available in places where they are not now available, our members could and would take advantage of them.

Mr. SPRINGER. I have been through Mr. Dubinsky's in New York, and I have seen it in operation while they were actually assisting members of the Garment Workers Union. I have not seen the one in St. Louis, but I heard about it. I think there was someone from Detroit who testified at the same time about one in Detroit. Is there one in Detroit?

Miss BAMBERGER. I may be wrong, but I believe this bill that you have before you now has never had hearings before this committee.

Mr. SPRINGER. Maybe you misunderstood me.

You do have group clinics, prepayment health plans, at least in those three cities now. I am talking about labor having them in those three cities. This was something which was undertaken by the individual unions themselves. As far as I can tell, the one I went through was very well done. Is this type of thing which you are now asking Federal funds for assistance on?

Miss BAMBERGER. The International Ladies Garment Workers Union Health Center in New York, and the Labor Health Center in St. Louis—there are several centers in St. Louis—both provide primarily ambulatory care. They are not the comprehensive prepayment plans.

Mr. SPRINGER. None of them are prepayment?

Miss BAMBERGER. They do not, by and large, provide comprehensive service. Most of the union health centers which were established beginning in the 1920's, I believe, when the ILGWU established its first centers, do not provide the kind of continuous, comprehensive

family-centered care that we are most anxious to see developed and expended today. The kind of programs that we are particularly thinking of as needing further encouragement are the comprehensive plans that are like the Health Insurance Plan of Greater New York, the Kaiser Foundation Health Plan on the west coast, the Community Health Association in Detroit, the Group Health Association here in Washington, D.C., all of which are community plans which operate with a considerable amount of labor support, and a large number of whose members are working people and their families who are covered through collective bargaining agreements.

It is this kind of plan that we hope to see extended further. It is this kind of plan, in fact, that the union health centers really gave the impetus to. This is the next step beyond the union health center.

Mr. SPRINGER. Are you talking about in addition to group clinic practice, the hospital care in connection with that also?

Miss BAMBERGER. A large number of these plans provide hospital benefits as well.

Mr. SPRINGER. Under this bill, are you asking, as part of the support from these funds, the hospital in addition to the group practice?

Miss BAMBERGER. I am not sure, Mr. Springer, whether hospitals could be built under the terms of this bill.

Mr. SPRINGER. At the present time you are not asking that, is that correct? At least as I read this bill, it does not provide it.

Miss BAMBERGER. The major need, if these plans are to expand, is the provision of physical facilities for the rendering of outpatient care. That is correct.

Mr. SPRINGER. This would be very similar to what you are practicing, say, in the Garment Workers Union, and also the one in St. Louis? This is largely outpatient care. What it is is clinic service, is that right, except that this is organized by labor and you get it by virtue of their setting up a clinic, either within the terms of their contract or the union supplying it itself at its own cost? Isn't that about right?

Miss BAMBERGER. The difference is that the plans that I have mentioned provide a more comprehensive array of services, which we believe is a very significant attribute of these kinds of plans, which makes it possible for them to maintain continuity of care and quality of care, which we consider very important.

Mr. SPRINGER. What you want, then, I take it, is something similar to what you already have, plus an expansion of the services; is that right?

Miss BAMBERGER. Some of our members are covered by the kind of plans that we hope will get an additional stimulus from this bill; yes.

Mr. SPRINGER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Pickle?

Mr. PICKLE. Miss Bamberger, on page 7 of your testimony, with reference to the mental health centers, you state that no source of funds other than the Federal Government can be expected to bear the initial burden of this development.

I assume you mean that if local funds were available or reasonably could be made available locally, that you would expect the local communities to do it. But if they don't have the funds, then it would go the Federal Government. Is that what you mean?

Mr. BEIDLER. Mr. Pickle, if I may comment on that, our objective has always been to get the kind of services that this country is rich enough to afford. We have no particular desire that they be performed by the Federal Government if they can be performed by the States or by the localities equally as efficiently.

Mr. PICKLE. Then if they could reasonably be furnished by the States or localities, you would expect them to meet that obligation, rather than going to the Federal Government.

Pursuing the same reasoning——

Mr. BEIDLER. I didn't say we would prefer that. What we want is the services.

Mr. PICKLE. Pursuing that same line of thought now in connection with the group practice measure, I assume, then, you would mean that if these services and these buildings could be put up and financed locally, you would expect that to be handled locally rather than by the Federal Government?

Mr. BEIDLER. I think I said we would not necessarily prefer that it be done locally. We want the services. I would say what we are looking for has not been done by the localities and by the States, and that is why we are looking to the Federal Government to do it.

Mr. PICKLE. I don't have any place in my State that I know of, any city, which has not been able to finance the construction of a group practice building if they approached either the banks or the local financing sources, or the Small Business Administration.

Why should we get the Federal Government into a field where there has been no demand and no deficiency in this respect?

Miss BAMBERGER. Mr. Pickle, you are going to hear, I believe, more, with more specific documentation later on today, about some of the demonstrated need for this legislation. Let me just say generally that the bill provides a priority system, in that there are three categories of eligible applicants for the loans or loan guarantees.

The third priority, the lowest, goes to medical and dental groups that may be organized on a profit basis. It is these groups that, by and large, have been able to get the financing from commercial sources. The nonprofit medical groups and those nonprofit groups that are associated with nonprofit prepayment plans have not, in the main, been able to get financing from commercial sources.

If the comprehensive prepayment plans are to be encouraged to spread, and if these are to be set up on a sound basis, it is important that they be able to make arrangements with doctors working in groups on a nonprofit basis, and it is those kinds of groups that have been having great difficulty in getting commercial financing for putting up buildings.

Mr. PICKLE. Are you speaking for the State of Texas?

Miss BAMBERGER. No, sir; I wouldn't presume to speak for the State of Texas.

Mr. PICKLE. I know of no instance where this hasn't been met locally, so I assume you are just speaking of a general, national approach.

Miss BAMBERGER. I am.

Mr. PICKLE. In my State, we have a prohibition against corporate practice. I don't think, under the terms of this measure, if it passed, our physicians could participate in this type of operation, the three phases.

How can my State be benefited, in a sense, by legislation in which they can't even participate?

Miss BAMBERGER. Mr. Pickle, I don't believe that the corporate practice of medicine and eligibility under this bill for Federal financial assistance are in any way connected.

Mr. PICKLE. I have reason to believe that there might be some connection, but I guess that is a matter of interpretation.

That is all, Mr. Chairman.

The CHAIRMAN. Mr. Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

I would just like to ask one question of Mr. Beidler.

You made the statement that the service should be of the caliber that we are rich enough to afford. How do you determine how rich you are, or how rich the Nation is, or how rich the State is?

Mr. BEIDLER. That is a question of judgment, sir. We believe that the Nation is rich enough, wealthy enough, to meet the basic requirements of its people, and the health requirements are among the most basic of those.

We believe that these come before some other of our needs and ought to be met and could be met in part by these bills.

Mr. YOUNGER. Do you think a State which has no indebtedness whatsoever, no bonded indebtedness, and a State which has several billion dollars of indebtedness are equal so far as their richness to carry on this work?

Mr. BEIDLER. I think the wealth of the State is composed of its industry, of the skills of its people, of its ability to create wealth.

Mr. YOUNGER. It has no relation as to what they owe?

Mr. BEIDLER. I don't claim to be an economist, but I look at our Nation as a very wealthy nation, as one which has great capacity to produce goods and services for its people. We are concerned that in producing those goods and services, a sufficient portion of those services will be devoted to the health care of its people, again through the kinds of bills we are supporting here today.

Mr. YOUNGER. I am just interested in your thoughts, since you are speaking for the AFL-CIO. I was just wondering whether in your mind, indebtedness has any bearing at all on the ability or the richness of the country to provide. Apparently it does not, and you base it on something else.

Mr. BEIDLER. I think indebtedness might have some relationship to it. I would like to point out in that connection that the per capita indebtedness of the Federal Government has decreased very substantially. I don't happen to have the figures before me now, nor do I recall them, but I would be glad to supply them to you.

The ability of anybody, an individual, a nation, or a State, to bear debt relates to its ability to produce wealth and our ability to produce wealth has been far outstripping our increase in the national debt.

Mr. YOUNGER. Thank you very much.

The CHAIRMAN. Mr. Huot?

Mr. HUOT. No questions.

The CHAIRMAN. Mr. Harvey?

Mr. HARVEY. Can you tell me whether the AFL-CIO, or any other union that you know of, has any program of its own to make loans for group practice centers from welfare funds or other funds?

Mr. BEIDLER. I am not aware that there is any direct program. We have encouraged our unions, those few unions that have representation in welfare funds, as trustees on welfare funds, to use those funds for socially useful programs. These loans would qualify, since there is an insurance guarantee.

Mr. HARVEY. But to your knowledge, the union itself has never made any loan for any group practice center such as we have been talking about here?

Miss BAMBERGER. I know of no use of union health and welfare funds to actually construct facilities with the exception of the very extensive hospital building program of the United Mine Workers in the Appalachia region. As you know, the UMW welfare fund is one of the very few—I believe it is something like 8 percent—where the unions have a substantial amount of control over how the reserves are expanded.

There have been a number of unions that have supported financially the setting up of new community health plans, including the Community Health Association of Detroit, where the UAW used funds in order to support the initial preparatory work, before it became a self-sustaining program. But this was not welfare fund money; these were union funds.

Mr. HARVEY. H.R. 2987 would give the Surgeon General the authority to make these loans or to insure these loans. Has the AFL-CIO considered the possibility of the Department of Housing and Home Finance Agency, for example, or FHA, taking over his function?

Miss BAMBERGER. Our only concern on that issue is that in the administration of this kind of a loan program, it is essential that there be people involved in the administration at a policymaking level who have some familiarity with medical care organization and with health care generally.

If there were a way to build the Public Health Service into the program without it being directly administered by the Public Health Service, we would have no objection.

Mr. HARVEY. Do you feel that the familiarity with the medical care is more important than the familiarity with making the loan, the appraisal or insuring of the loan?

Miss BAMBERGER. As I understand it, under the present provisions of the bill, the expertise of the people who know specialize in making commercial loans would be available to the Public Health Service in its administration of the program. If that arrangement were reversed, I think there would be no problem. I think both of those talents and skills have to be involved in the administration of the program.

Mr. HARVEY. Thank you.

I have no further questions, Mr. Chairman.

The CHAIRMAN. Mr. Gilligan?

Mr. GILLIGAN. I have no questions.

The CHAIRMAN. Mr. Farnsley?

Mr. FARNSLEY. I have no questions, Mr. Chairman.

The CHAIRMAN. Dr. Carter?

Mr. CARTER. First, I want to compliment the AFL-CIO on its selection of such an attractive and intelligent witness which, of course, has an important bearing upon the testimony.

I take it, Miss Bamberger, that the main interest of your group is obtaining funds for group practice, for groups which are nonprofit organizations which will then employ doctors; is that true?

MISS BAMBERGER. As you know, Dr. Carter, there are many, many different kinds of arrangements under which doctors practice in groups. There are partnerships, there are doctors who have an employment relationship with industry, with a hospital, a medical school, and sometimes with a comprehensive prepayment plan.

MR. CARTER. Just what group do you refer to? That is what I am asking. I would not want a generalization, but a specific answer.

MISS BAMBERGER. The essence of group practice, what we want to see supported, is doctors practicing together in groups, sharing equipment, sharing facilities, sharing auxiliary staff, and cooperating with one another. What economic arrangements they make in order to do this, whether they set themselves up in the way that the doctors at the Mayo Clinic have set themselves up, which involves partly partnership, partly salaried practice for the more junior men, or whether they do it in the way that the doctors in the Health Insurance Plan of Greater New York have done it, where they are in partnership, where the partnership has a relationship to the prepayment plan—that, we believe, is not the essence of the question.

The essence is doctors practicing in groups, a principle which has received the endorsement of a large number of very outstanding and prominent people in the medical field as a way of organizing the provision of medical care.

MR. CARTER. I take it, then, from your familiarity with these groups, that you know the desires of these physicians. Have you been approached by groups of physicians who cannot obtain money for group practice?

MISS BAMBERGER. No; I don't believe the AFL-CIO has heard from any groups of doctors who want to set themselves up in group practice. We have heard from a great many doctors who say that they would like to work out an arrangement, a prepayment arrangement, with a group of consumers, and they would hope that we could put them in touch with local groups of consumers interested in organizing a medical care program.

We have done that, and we have found very often that planning falls apart at the stage where money is required to set up the necessary facilities.

MR. CARTER. It is my understanding that the AFL-CIO is quite a wealthy union, has quite large funds. As you stated, the UMW built several hospitals in eastern Kentucky and neighboring Virginia. Why doesn't the AFL-CIO invest its vast amount of money for furthering their interest in the health fields?

MR. BEIDLER. If I may respond to that, Doctor, I am afraid you are misinformed. The AFL-CIO itself has very limited funds, as a matter of fact. Most of the international unions affiliated with the AFL-CIO have limited funds in terms of their general funds. There are very large amounts of funds in some unions which come under health and welfare plans which are, of course, controlled by trustees, pension funds, and so forth, which can be invested only, in effect, in court-approved investments. Funds invested under this bill would be such funds because the Federal Government would insure them up to 90 percent.

Mr. CARTER. That is true. I understand, however, that while some sizable sums of money were spent in the last election, from what I read in magazines, although I don't know where they came from, I understand it was from the ALF-CIO.

Certainly there are some points in this which are all right. If there is a need for this sort of thing, I would be for it. It happens I am from the Appalachians. It happens also that I am a member of a group practice which was established without Federal aid. There is another group in that area of the same type. Where there is a need, certainly I am for it. It makes it easier for me. But I feel that if we can depend upon our own initiative, it would be better.

Thank you, Mr. Chairman.

Mr. VAN DEERLIN (presiding). Mr. Callaway.

Mr. CALLAWAY. I would like to confine my questions to H.R. 2987, to the mortgage features of the bill. A purpose of the bill is to contribute to a more effective distribution of physicians in the smaller communities. I think this is a worthwhile purpose, and I would like to refer to my own State of Georgia where, for a number of years, we have worked in this direction.

We have worked to give an incentive by giving loans to doctors who practice in small communities. The doctor can pay for his medical schooling either in dollars or by his practice in the small community. This is where the need seems to be in Georgia. Most of these situations are single doctor cases.

When you get to communities of 10,000 or 15,000, you get into group situations. The need here is not so severe in my State, as in the small community, 15 or 20 miles from another community, where it is a single doctor situation.

Do you see a conflict in this? Do you see that when we make it easier for groups to get together, we are, in fact, enticing this doctor, whom we are trying to get into a solo situation, to go to a group situation, thus taking him away from the smaller community?

Miss BAMBERGER. I hesitate to answer this question, because I know that here in the room there is a witness who has more experience related to providing medical care in smaller communities than probably anyone else in the United States. I hope you will have the opportunity to ask him as to what group practice can do in providing high-quality care in a rural setting.

I think it is pretty well agreed that the best of medical care cannot well be given by doctors practicing in isolation in a rural setting, and that especially in the rural setting it is important to realize the opportunity for doctors to get together in groups with some sort of outreach clinics, satellite clinics, satellite stations—where not only the one general practitioner but a pediatrician, an obstetrician-gynecologist, and so on, can rotate through, as made possible through group practice.

This kind of thing holds the greatest promise of bringing high-quality care to rural people, as well as to city dwellers. Therefore, I see the needs of rural areas not as a contradiction of the purposes of this bill, but as another argument for the spread of group practice.

Mr. CALLAWAY. We have felt in Georgia, perhaps mistakenly, that it was vital to get physicians to live in the small communities and to have a solo practice of medicine. I agree that groups with various skills are certainly most worthwhile. But I feel that our communities in the southern part of the State, at least, are so sparsely settled that

we couldn't really count on most areas having this kind of assistance. Are we looking at the problem in the wrong way?

Miss BAMBERGER. The bill we are supporting would help to meet the need that you describe. Visualize a group practice which has specialists as well as general practitioners in one of the larger population centers within a rural area.

Working out of that can be the general practitioner who lives in the smaller community but who is working very closely with the specialists who come around and rotate through the clinic that he may be maintaining.

Dr. CARTER is smiling—I am sure that he has experience along this line, and I would suspect this would back up the point I am making. General practitioners backed up by specialists associated in a group practice framework can do a much better job for the people that they are trying to serve.

Mr. CALLAWAY. I think your theory may well be correct, but as I see it in an isolated area such as the southern part of our State, it might not necessarily work.

Mr. CARTER. Would the gentleman yield?

Mr. CALLAWAY. Yes.

Mr. CARTER. It is rather difficult to get the specialists to come around in an isolated area.

Miss BAMBERGER. I don't know whether it is permitted for a witness to ask a member a question, but do you think it might be conceivable that it would be easier to get these specialists to go into the isolated areas if there were funds for the facilities where they could practice?

Mr. CARTER. The facilities are there in most cases now, but they certainly haven't come around to fully satisfy the wish.

Mr. CALLAWAY. It seems to me that this is a bill particularly for doctors, to provide doctors with better terms for mortgages. Yet the American Medical Association is opposing the bill and their spokesmen said that they have had no request from doctors.

Would you care to comment on that?

Mr. BEIDLER. Quite the contrary, the purpose of these bills is to bring better health care to the people, not to enhance the well-being of the doctors, but to enable them to bring better health care to the people.

Mr. CALLAWAY. Wouldn't the loans be to individual doctors or groups of doctors?

Mr. BEIDLER. They could be, or to group practice plans of any kind.

Miss BAMBERGER. There are three categories of applicants for the loans and loan guarantees. Among these three there is priority listing. The first is a private agency or organization, including a medical or dental group, undertaking to provide directly, or through arrangements with a medical or dental group, comprehensive medical care or dental care, which may include hospitalization, to members or subscribers, primarily on a group practice, prepayment basis. This first category is the one that I was emphasizing in my testimony, in describing our conviction that when you combine group practice with prepayment, the health needs of people are better and more economically met.

The second is a private or nonprofit agency which is established for the purpose of improving the availability of medical or dental care.

The third is a medical or dental group, which would include a profitmaking group.

Mr. CALLAWAY. I would suspect that the opposition of the doctors is because they anticipate the effect of this bill will be more toward the first group and less toward the profit oriented. I would have to stick up for the doctors who have been profit oriented by saying we have received pretty good medicine through doctors who believe in profit, and I don't believe there should be any criticism of a doctor who is interested in making a profit.

Mr. YOUNGER. Would the gentleman yield?

Mr. CALLAWAY. Yes.

Mr. YOUNGER. I want to take exception to the statement you made a while ago, Mr. Beidler, inferring that the doctors' only concern is their own well-being and they are not interested in public health.

Mr. BEIDLER. I never intended any such reference, Mr. Younger.

Mr. YOUNGER. I think you ought to correct it for the record.

Mr. BEIDLER. All I was saying was that the bills here are intended primarily to improve health services to the people and that is our objective in asking that they be passed.

Mr. YOUNGER. But inferring that if the doctors objected to one of them, they were objecting because it would interfere with their income or their well-being and not that they were concerned about public health. I don't think that is true.

Mr. BEIDLER. I think you must have misinterpreted what I said, because I did not intend any such thing.

Mr. YOUNGER. May I ask the reporter to read his statement back, please?

(The record was read by the reporter.)

Miss BAMBERGER. These bills will be of substantial assistance to physicians in bringing better health care to people, and they will be of assistance to people in obtaining better health care.

Mr. YOUNGER. You agree that their testimony, because they oppose one bill, doesn't necessarily mean that they are against public health and the welfare of the people?

Mr. BEIDLER. I certainly never intended to suggest that that was the case.

Mr. YOUNGER. That is all.

Mr. VAN DEERLIN. Are there further questions?

Mr. CARTER. Will the gentleman yield?

Mr. CALLAWAY. Yes.

Mr. CARTER. In our section of Appalachia we have had one hospital since 1953, and there are two groups of physicians. In that length of time, no one has been turned away from our hospital. We have been trying to do our best as physicians to help the people in our area.

Thank you.

Mr. CALLAWAY. I have no further questions, Mr. Chairman.

Mr. VAN DEERLIN. In that case, the morning session is adjourned. Thank you, Miss Bamberger and Mr. Beidler.

The committee will reconvene at 2 p.m. to hear representatives of the Group Health Association of America.

(Whereupon, at 12:15 p.m., the committee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

The committee reconvened at 2 p.m., Hon. Oren Harris (chairman of the committee) presiding.

The CHAIRMAN. The committee will come to order.

The first witness this afternoon will be Dr. Caldwell B. Esselstyn, executive director of the Community Health Association of Detroit and a member of the executive committee and past president of the Group Health Association of America.

STATEMENT OF CALDWELL B. ESSELSTYN, M.D., EXECUTIVE DIRECTOR OF COMMUNITY HEALTH ASSOCIATION OF DETROIT AND MEMBER OF THE EXECUTIVE COMMITTEE AND PAST PRESIDENT OF GHAA; ACCOMPANIED BY W. PALMER DEARING, M.D., EXECUTIVE DIRECTOR, GHAA, AND HAROLD NEWMAN, D.D.S., DENTAL DIRECTOR, GROUP HEALTH ASSOCIATION, INC., WASHINGTON, D.C.

Dr. ESSELSTYN. Dr. Dearing and Dr. Newman will accompany me, Mr. Chairman.

The CHAIRMAN. Dr. Dearing is the executive director of Group Health Association of America?

Dr. ESSELSTYN. That is right.

The CHAIRMAN. You may proceed, Doctor.

Dr. ESSELSTYN. Thank you.

My name is Caldwell B. Esselstyn. For the past 24 years I have been a practicing surgeon and medical director of the Rip Van Winkle Clinic in rural upstate New York. Several months ago I became executive director of the Community Health Association of Detroit. This is a prepaid, nonprofit, comprehensive group practice-prepayment plan now in its fourth year. Currently we provide comprehensive medical care for some 69,000 men, women, and children in the Greater Detroit area.

I appreciate this opportunity to appear before your committee today representing GHAA.

The Group Health Association of America is the focal point in this country and Canada for those health plans which endorse the principles of group medical practice, comprehensive care, prepayment, operation on a nonprofit basis, with control of professional standards and medical practice by qualified physicians. Today these programs are serving some 5 million people and this number is steadily growing.

With me are two of my respected associates, who are assisting my representation of the Group Health Association of America. They are Harold Newman, D.D.S., dental director of the Group Health Association, Inc., of Washington, D.C., a nonprofit prepaid plan which has functioned in our National Capital for some three decades, and Dr. W. Palmer Dearing, formerly Deputy Surgeon General of the U.S. Public Health Service and now executive director of the Group Health Association of America.

On the basis of resolutions formally adopted by its membership meetings, and by its executive committee, GHAA has repeatedly endorsed the principle contained in H.R. 2987 of Government guarantee of mortgages for the construction of group medical facilities,

together with a Government loan fund for the groups which cannot otherwise find financing.

Specifically, the Group Health Association of America, by its representation here today, gives strong support to the provisions contained in H.R. 2987 introduced by Representative Harris, of Arkansas, and in the similar bill H.R. 4888 introduced by Representative Rhodes, of Pennsylvania.

We respectfully urge the committee to act favorably upon this bill for the following reasons:

1. In spite of the fact that the best in medical care is available in this country, national vital statistics do not suggest that we are the healthiest country in the world. We know that we are not the country with the greatest longevity, nor the country with the lowest maternal mortality. It is lamentable but true that just recently the United States has slipped to 11th place in infant mortality among other countries of the world which are assembling statistics in comparable fashion under the leadership of the World Health Organization. We are reminded of the statement of Luther Terry, our Surgeon General, to the effect that 150,000 lives would be lost and a million disabilities take place in the course of a year simply because of the failure to apply medical knowledge and techniques which are already at our disposal.

By making comprehensive medical care available on a nonprofit basis to an increasing segment of our society, the group health direct service plans are making a major contribution toward providing easier access to good medical care. It is interesting to note in this connection that in the year 1955 the prenatal mortality of one of our member organizations, namely the Health Insurance Plan of Greater New York, was 23.9 per 1,000 live births and foetal deaths, as compared with 38.1 for New York City. This is further evidence of the ability of these programs to bolster our national health levels in needed areas. Yet the lack of initial capital is one of the major barriers to the establishment of new prepaid programs.

2. The spiraling costs of medical care give all grave concern today. The major thrust of health legislation to date has been in the direction of providing more financing for existing patterns of care. Repeated studies have shown the ability of the group health plans to provide high quality care economically. I would like to refer to only one study specifically, carried out by Dr. George Perrott, formerly director of the Research and Statistics Department of GHAA. This was a study of the most recent utilization of services under the Federal employees health benefits program. A copy of this study is attached to my testimony, and I would request that this be incorporated in the record. Would that be acceptable, Mr. Chairman?

The CHAIRMAN. What do you have reference to?

Dr. ESSELSTYN. The "Utilization of Hospital Services Under Federal Employees Health Benefits Program," by George S. Perrott.

The CHAIRMAN. Yes, it may be included with your statement.

Dr. ESSELSTYN. Thank you.

(The statements referred to follow:)

UTILIZATION OF HOSPITAL SERVICES UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM¹

(George S. Perrott, Consultant, Group Health Association of America, Washington, D.C.)

This paper gives statistics on the hospital experience of Federal employees covered under five broad types of voluntary insurance in the Federal employees health benefits program. It presents a comparison of hospital utilization rates among persons covered by these plans—Blue Cross-Blue Shield, indemnity, employee organization, individual practice and group practice plans. The data show a relatively low rate of hospital utilization among individuals insured in the group practice prepayment plans, a finding in agreement with a number of (but not all) other studies.² The paper gives one small segment of the voluminous data on medical and hospital services reported to the U.S. Civil Service Commission.

The writer wishes to express his appreciation to Mr. Andrew E. Ruddock, Director, Bureau of Retirement and Insurance, U.S. Civil Service Commission, for permission to study the reported data on utilization of health services and to Dr. Joseph Zisman, Supervising Statistician, Office of the Actuary, for his unfailing cooperation and patience in guiding him through the data.

ENROLLMENT

Some 6¾ million employees and their dependents were eligible on June 30, 1964, to obtain prepaid medical care under the Federal program. Of these, 85 percent were in high option and 15 percent in low option plans; of all enrollees, about 57 percent were in the Blue Cross-Blue Shield Government-wide plan, 21 percent in the indemnity Government-wide plan, 16 percent in employee organization plans, 4 percent in group practice prepayment plans and the remaining 2 percent in individual practice plans. Annuitants numbered nearly 161,000 or 7.5 percent of the total of employees plus annuitants. As Mr. Ruddock has pointed out in his paper, this number and percentage is on the increase and this fact has significant actuarial implications.

PUBLISHED REPORTS BY COMMISSION

The program began on July 1, 1960, and data for three contract periods have been accumulated: I. July 1, 1960 to October 31, 1963. II. November 1, 1961 to October 31, 1962 and III. November 1, 1962 to October 31, 1963. Data on financial operations and enrollment together with some information on utilization of services have been published by the Commission in its annual reports for the fiscal years ending June 30, 1962 and June 30, 1963 (the first and second contract years). In these reports, the utilization figures (largely hospitalization) are not related to the covered population or to the persons receiving benefits, so that the significance of the figures is not determined easily by inspection. However, there is a wealth of material in the reports and a number of interested persons, among them the writer, have studied the published data further.

METHOD OF REPORTING

Before presenting any figures, it is in order to say a few words about the manner of collection of the data. The Commission receives monthly reports from most of the plans on claims and benefits classified by option, as maternity and non-maternity, and by dependency status. Quarterly reports are received on enrollment of employees and annuitants by option and family status. Other actuarial data having to do with claims and benefits are also obtained.

The detailed data on utilization of health services are reported by the plans to the Commission in January for the preceding contract year ending October 31. These are submitted as statistical tables. This is done rather than to process raw data centrally because the Commission does not wish to expend funds on a large statistical program at the expense of providing health services.

¹ To be presented at the joint session, Group Health Association of America, and the Medical Care Section, Wednesday afternoon, Oct. 7, 1964. The study was part of a program supported by a grant from the Division of Community Health Services, U.S. Public Health Service.

² Riedel, Donald C., and Fitzpatrick, Thomas B., "Patterns of Patient Care." Research Series No. 4, Ann Arbor, Mich. University of Michigan, 1964. See also, Dearing, W. P., "Developments and Accomplishments of Comprehensive Group Practice Prepayment Programs." Based on a report prepared for the American Medical Association's Third National Congress of Voluntary Insurance and Prepayment. Feb. 15-16, 1963. Group Health Association of America, Washington, D.C., 1964.

See also, Klarman, Herbert E., "Effects of Prepaid Group Practice on Hospital Use." Public Health Reports. 78:955-965 (November) 1963.

This procedure has produced adequate financial and other data for administrative purposes but has resulted in some problems in interpretation of the details of annual reports on utilization of services. These include (1) comparable definition of terms, (2) uniformity of statistical tables, (3) uniformity of sampling procedures, (4) adequate data on the covered population to use as a base for the reported utilization data. The panel may want to consider these matters in further detail. The charts which I shall present give data selected with these limitations in mind and, in my opinion, the comparisons shown are valid.

ANALYSIS OF PUBLISHED REPORTS

The writer made a brief analysis of the published figures on hospital utilization for the first and second contract periods which appeared as special supplements to Group Health and Welfare News in March 1963 and March 1964. The analysis (see GHAA special supplement attached) showed that members enrolled in group practice prepayment plans, both options, during the second contract year (1961-62) used 454 nonmaternity hospital days per 1,000 persons covered as compared with 826 days per 1,000 persons for Blue Cross, 729 for employee organization plans, 708 for the Government-wide indemnity plan, and 538 for individual practice plans. The 2 Government-wide programs combined showed a hospital utilization of 791 days per 1,000 persons, or nearly 75 percent higher than the group practice plans. These rates were not given in the reports published by the Commission but were calculated by dividing the figure "Hospitalization, inpatient services, days" by the figure "Average number covered" as shown in table 0-3 of the published report.

The data also showed that each individual group practice plan had a considerably lower utilization rate than either Blue Cross or indemnity Government-wide plans with the exception of Hawaii which had a rate about equal to that of the indemnity plan.

RATES FOR 3 CONTRACT YEARS

Figure 2 gives the same type of data for each of the 3 contract years. While there is some variation from year to year, it is obvious that the same relation holds in general. The rate for Hawaii in the third contract year is lower than in the other 2 years and considerably lower than either Blue Cross or Indemnity plans for that year.

STATE COMPARISONS BY PLAN

In figure 3, unpublished data for 1961-62 have been used in a comparison of the various plans in the States where sizable group practice plans are in operation—California, Oregon, Washington, New York, and the area comprising Maryland, Virginia, and the District of Columbia. (Over one-half of the membership of Group Health Association, Washington, D.C., resides in Maryland and Virginia.) Plans with 200 or fewer persons receiving hospital benefits are omitted. The relative position of the group practice plans seems unaffected by geography.

COMPARISONS BY OPTION

In figure 4, hospital utilization for maternity and nonmaternity cases, 1961-62, is compared for the broad groups of plans for persons covered by high and by low option provisions. High-option enrollees used more nonmaternity care than low-option enrollees although the difference was small in the case of the group practice plans (individual plans had only a few hundred in the low option). The lower utilization by low-option enrollees was evident also in the maternity utilization rates with the exception of the group practice plans, which showed a slightly higher rate for low option in terms of days per 1,000 persons. This was the net result of a slightly lower rate in terms of persons receiving maternity benefits (18 per 1,000 high option, 17 per 1,000 low option) and longer stay per person receiving benefits (4.3 days high option; 5.3 low option). The reason for the lower maternity rate in the low option for the other plans is not evident in the statistical data on age, sex, and family size. It may be a selective bias due to the reasons for a family selecting high or low option which is not described by the available statistical indexes.

COMPARISONS BY AGE GROUPS

In figure 5, nonmaternity hospital utilization, 1961-62, by age groups for employees and annuitants is compared for the Blue Cross plans in the United States (1,063,850 persons) and the group practice plans in the States shown in figure 3 with the addition of Hawaii (80,000 persons). Whether in terms of hospital

admissions or hospital days per 1,000 persons, the utilization by group practice members is considerably less than that of the Blue Cross members in each age group. The figure for days per admission shows no particular trend; it is the difference in admission rates that is responsible for the lower utilization by group practice enrollees. Data for employees and annuitants were used, rather than for the whole population including dependents, because many of the group practice plans do not report utilization by age for dependents.

In considering these comparisons by age groups, it should be borne in mind that the Blue Cross data are for the United States and the group practice data are for those States in which the plans operate. While the writer doubts that a different picture would be shown if age-specific comparisons were available for the all-age figures by States shown in figure 3, he cannot show such comparisons since such data are not reported to the Commission. Dr. Riedel is preparing some new tabulations which should add to our information on this point.

SURGICAL PROCEDURES

Comparisons of the rates of hospitalization for surgical operations undergone by members of the several plans are of particular interest. In figure 6, the data (1961-62) show a tonsillectomy rate for the Government-wide Blue Shield plan over 2.5 times that of the group practice plans; for "female surgery" (mastectomy, hysterectomy, and dilation and curettage, nonmaternal) 1.5 times that of group practice; and a rate nearly twice as high for appendectomies among group practice enrollees. In the case of female surgery, the difference is due largely to the lower rate for mastectomy and hysterectomy among group practice subscribers, rates for dilatation and curettage being not far different for the two plans. In these comparisons the population base is all persons including dependents, a total of 231,300. The distribution by age is as follows:

Group practice, November 1961-October 1962

Age	Number	Percent	Age	Number	Percent
All ages.....	231,300	100.0	45 to 54.....	33,770	14.6
Under 19.....	97,690	42.2	55 to 64.....	17,275	7.5
19 to 34.....	35,715	15.4	65 and over.....	4,530	2.0
35 to 44.....	42,320	18.3			

Age specific utilization data are not available; however, the percentage composition seems not far different from what might be expected for the Blue Cross population for the same period.³

MENTAL ILLNESS

A different comparative picture is presented for hospitalization of mental illness. When compared by diagnosis, group practice plans show lower hospitalization rates for the second contract year for most diagnoses, especially mental illness. Here the comparative annual rates expressed as annual hospital days per 1,000 persons are:

	All diagnoses except maternity	Mental and nervous disease
Blue Cross.....	826	34
Indemnity.....	708	83
Group practice.....	455	1.5

The difference is accounted for in benefit provisions, the group practice plans providing relatively meager benefits.

³ See Josephson, Carl E. and coworkers. Hospital Utilization and Covered Charges of Federal Employees Under Service Benefits. Blue Cross Reports. 2: 1-16 (Jan.-Feb.) 1964.

CONCLUSION

This paper has not attempted to present any of the voluminous data available on charges and benefits classified by age, sex, dependency status, diagnosis, operative procedure, etc. The writer has made a beginning at analysis of these data and plans to present them in another paper.

The utilization data from the Federal employees health program operation are a potential source of information on health and health services which have considerably broader application than the operation of the program itself. While it is realized that the Commission is not justified in using any large proportion of the premium dollar for anything but the essentials of administering the program, it is to be hoped that cooperative arrangements with research organizations might be worked out which make possible studies of this valuable material without expense to the policy holders. The writer trusts that the panel will consider this problem.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM UTILIZATION OF HOSPITAL SERVICES

(By George S. Perrott, Consultant, Division of Research and Statistics, Group Health Association of America, Washington, D.C.)

Charts from a paper presented at the annual meeting of the American Public Health Association, Joint Session of Medical Care Section and Group Health Association of America, October 7, 1964, New York, N. Y.

FIGURE 1

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
2nd Contract Year - November 1, 1961 - October 31, 1962
Comparing Rate of Surgical Procedures for Blue Shield and Group Practice
Non-Maternity In-Hospital Services, Both Options

SURGICAL PROCEDURE RATE PER 1,000

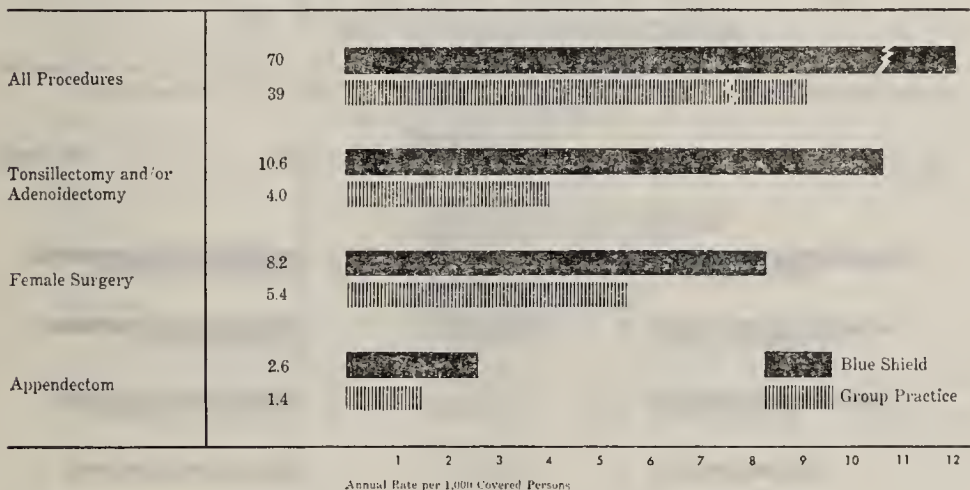


FIGURE 2

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
2nd Contract Year—November 1, 1961—October 31, 1962

**Comparing Hospital Utilization between
 Group Practice Prepayment and Blue Cross Plans
 Non-Maternity In-Hospital Services, Both Options
 Employees and Annuitants**

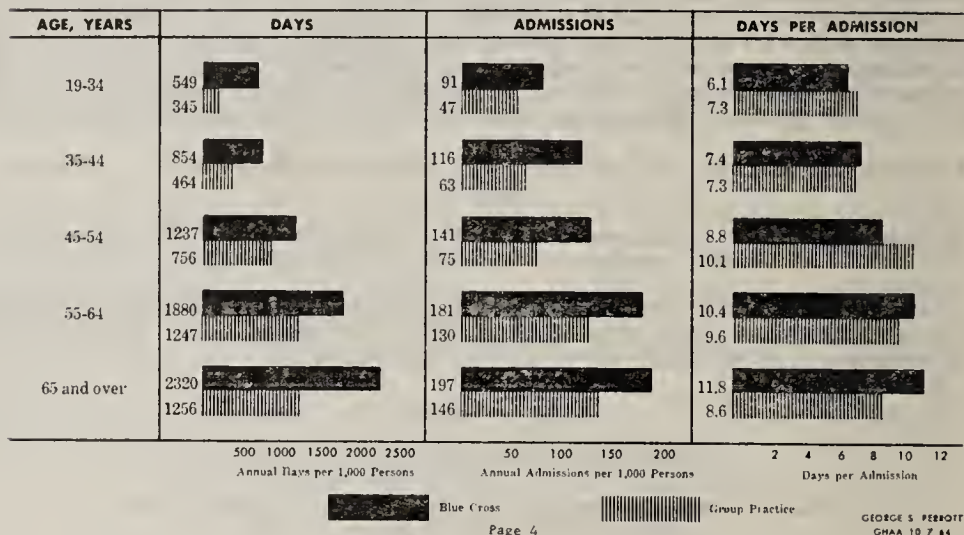


FIGURE 3

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

2nd Contract Year November 1, 1961—October 31, 1962

Comparing Non-Maternity In-Patient Hospital Utilization Rates by Plan and Option

Comparing Maternity In-Patient Hospital Utilization by Plan and Option

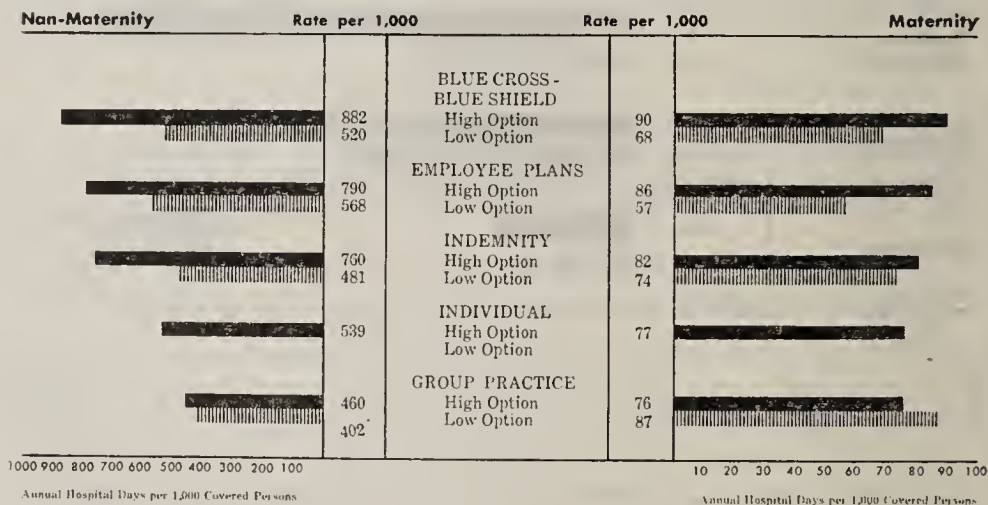
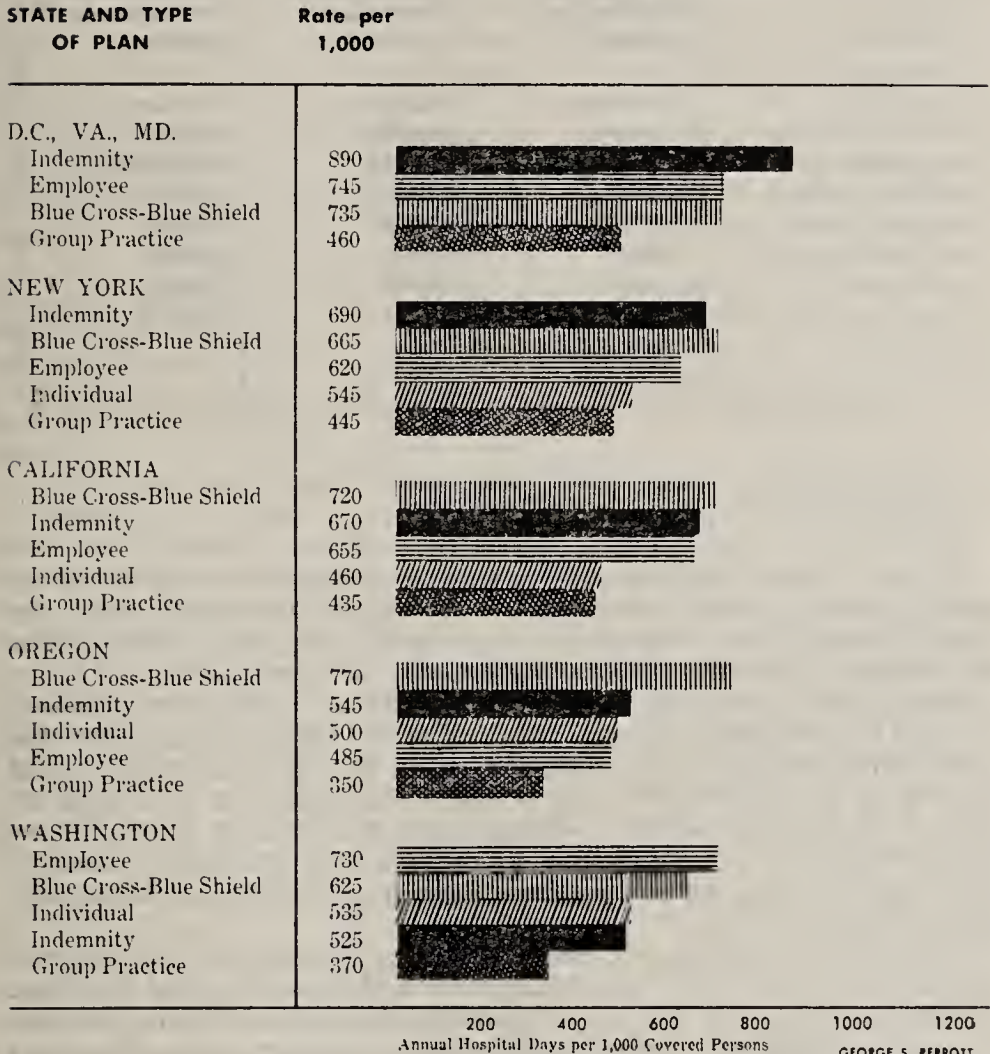
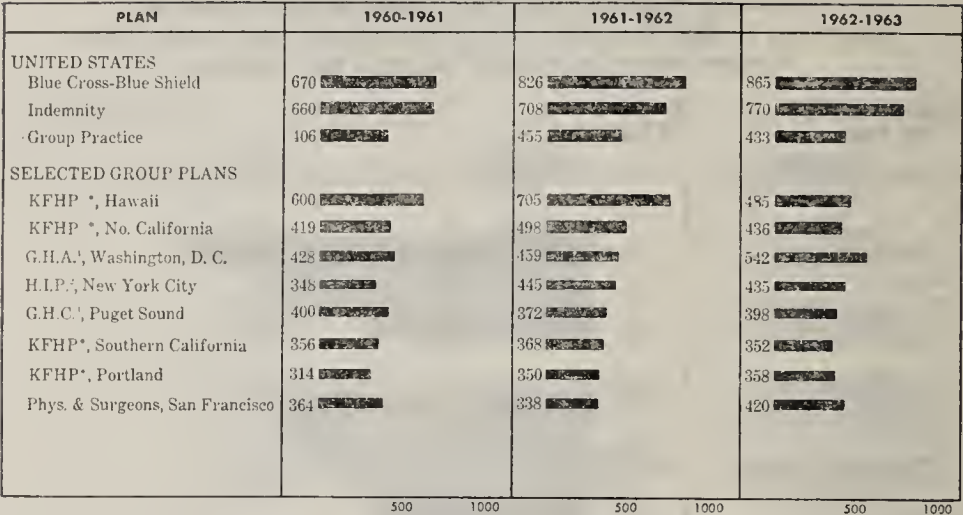


FIGURE 4

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM**2nd Contract Year – November 1, 1961 – October 31, 1962****Comparing Hospital Utilization Among Several States for
Indemnity, Service, Employee, Individual and Group Practice Plans
Non-maternity In-hospital Services, Both Options**

GEORGE S. PERROTT
GHAA 10 7 64

FIGURE 5
FEDERAL EMPLOYEES HEALTH PROGRAM
Experience for Three Contract Years
Non-Maternity In-Hospital Services, Both Options



* Kaiser Foundation Health Plan
¹ Group Health Association
² Health Insurance Plan of Greater New York
³ Group Health Cooperative

In-patient — Annualized Rate per 1,000 Covered Persons

Dr. ESSELSTYN. As you can see, this study shows that in the group health plans there was 40 percent less hospital utilization, that the appendectomy rate in programs other than the group health plans was doubled, that the rate of tonsillectomies was two and a half times as great, and the rate of female surgery (breast and hysterectomies) one and a half times as great. Had all of the beneficiaries under this nationwide program been under the group health plans, there would have been an estimated saving of some \$55 million in this program alone. The group health programs across the country have demonstrated their ability repeatedly to provide this economical kind of care, but the plans do not generate enough money for capital investment, help is essential.

3. We have noted that in previous years, a great deal of interest has been directed toward providing more and better hospital facilities. This leaves as one of the major problems the organization of out-of-hospital services in an orderly and efficient manner, where there can be the same kind of accountability and visibility as is provided for in-hospital care. We feel the time has come when there should be the same kind of encouragement for the growth and development of those institutions dedicated to keeping people out of hospitals as has been demonstrated in the past toward those programs interested in establishing more hospitals. We must always remember that the hospital is not, after all, the last word, but the last resort.

4. Why have the group health plans found it difficult to obtain funds for capital construction? For many years organized medicine has been extremely sensitive in the area of group practice. Whereas today, in most areas of the country, this is now a method of practice accepted by organized medicine even at the local level, group practice associated with prepayment plans is still vigorously resisted at the

local level by organized medicine almost universally. In many areas, particularly in more rural areas members of county medical societies are frequently members of the boards of directors of money loaning institutions such as commercial banks. Their lack of sympathy with these programs has often cut off this source of potential capital funds. The trend in recent years for banks to coalesce has magnified the area denied group practice programs for the same reason.

The construction, furthermore, which is specialized, does not lend itself to other uses if the building were to be abandoned for whatever reason. Here again we see a reason for the difficulty of plans in obtaining loans.

5. Although, by and large across the country, programs which have been successfully launched have continued to succeed, there have been failures recorded, particularly in the early years. This record provides an added risk which has not been overlooked by lending agencies.

6. Since one of the main contributions of the group practice programs is the emphasis on the ambulatory patients and providing services out of the hospital, these group practice clinics, of necessity, are costly, particularly those not associated with a hospital and which must therefore include all of the diagnostic laboratory and X-ray facilities which are found in the modern hospital today and are so essential.

7. I am aware of the fact that Blue Cross premiums have gone up 83 percent in the last 12 years and I am also aware of the fact that Blue Cross plans have been repeatedly investigated to determine whether or not they were functioning in an economic way. In New York State there is an interest at the present time in investigating hospitals more carefully to make sure that these facilities are being run in the best interests of the consumer. In my opinion, a small amount may be saved in the Blue Cross area, perhaps some here and there in the hospital area, but the major hope for the control of spiraling costs of medical care lies in a change in the conventional method of practice. Conventional, solo practices or conventional proprietary group practice, with income based on fee-for-service, have both shown inflationary tendencies. Practice by physicians who are organized in nonprofit groups and have been liberated from the yoke of fee-for-service or piecework medicine and who are provided the opportunity of practicing, while being assured of a known annual income, mutually acceptable to consumer and producer, has demonstrated beyond any doubt substantial potential savings. It is of the greatest importance to encourage the growth of these plans now for this reason.

These are but some of the reasons because of which GHAA, to which more than a score of these nonprofit group health plans belong, welcomes the views expressed by President Johnson in his health message to the Congress on January 7, 1965, in which he stated:

The initial capital requirements for group practice are substantial, and the funds are not now sufficiently available to stimulate the expansion and establishment of group practice. To facilitate and encourage this desirable trend, I recommend legislation to authorize a program of direct loans and loan guarantees to assist voluntary associations in the construction and equipping of facilities for comprehensive group practice.

GHAA furthermore notes with approval the views submitted by the Secretary of Health, Education, and Welfare to this committee earlier this week. We particularly agree with the Department concerning the benefits which this will produce for the American public.

This House committee has received testimony about the need for new group practice facilities, about the higher cost of plant and equipment arising from the spiraling complexity and sophistication of medical treatment. I would like to report to the committee on a survey which was made by our executive director, Dr. Dearing, after these hearings were scheduled. A brief telegraphic survey of some of our member organizations revealed the following estimates of needs of these group health plans for construction and equipment for the fiscal year ending June 30, 1966, as well as for a period of the next 4 years. These replies are enlightening and indicate the substantial growth that might be anticipated in the event this financing is made more easily available as a result of this proposed legislation.

The Kaiser organization on the west coast for instance, on the basis of fairly close planning, foresees the need of up to \$25 million to finance the construction of new clinics for the care of ambulatory out-of-hospital patients.

The Health Insurance Plan of Greater New York, now serving over 700,000 people in the five Greater New York boroughs, visualizes seven new locations for ambulatory facilities at a cost estimated at approximately five and a half million dollars.

Right here in Washington, the local Group Health Association urgently needs equipment for contemplated new centers at a cost estimated at approximately \$200,000.

The Community Health Association in Detroit needs a minimum of a million and a half dollars to provide adequate facilities for ambulatory patients in the coming year because of growth and development.

A number of the replies to the GHAA survey came from locations in what has come to be known as Appalachia, an area where almost every authority agrees there is urgent need for expansion of medical facilities. We were told by our members in towns in Kentucky, Virginia, and West Virginia of hopes for expansion of facilities at a cost totaling at least a million dollars in the next fiscal year alone. Let me emphasize that these Appalachia figures are for only one 12-month period, and the possible growth over the longer run is proportionately even more substantial.

It should also be noted that these estimates of construction do not include plans for hospitals at all.

Also, I want to emphasize GHAA's approval of that portion of the bill which directs the program toward smaller communities and toward group practice medical or dental units sponsored by cooperative or nonprofit organizations. It is our feeling that these are the areas where support will be the most rewarding.

We believe that many benefits can arise also through the provision of "technical assistance in the planning for and construction of group practice facilities" that the Surgeon General is authorized to provide under section 907(a). All too often, absence of these skills has resulted in serious handicaps at the very start of programs.

We also feel that it is important for guaranteed loans to run for terms of 25 years. These programs have demonstrated their ability to provide economical care and also to generate enough income so

that modest amortization rates plus low interest rates can be maintained.

The provision of capital loans, which in many instances is the single barrier preventing the establishment of these much needed programs, can be made available only through Government guarantees and a standby Government loan program when mortgage money is not available from private sources. These guarantees will furthermore be catalytic, in that they will help to stimulate investment by nonprofit organization funds, foundations, and other similar groups which, with the help of a Government guarantee, will feel it possible to make these socially valuable investments.

In summary, then, the Group Health Association of America endorses H.R. 2987. We believe its provisions are sound and carefully drawn. Our own long experience in the field of prepaid group health care has convinced us of its wisdom, and the facts point to an existing need. We urge favorable action on this bill at this time.

Thank you.

The CHAIRMAN. Thank you, Doctor.

Dr. Dearing, do you have anything further to offer?

Dr. DEARING. No, sir, Mr. Chairman.

The CHAIRMAN. You are just here supporting Dr. Esselstyn?

Dr. DEARING. And to assist in case there are any questions, sir.

The CHAIRMAN. I observe in addition to the survey referred to on the utilization of hospital services under the Federal employees health benefit program that Mr. Perrott also has charts on the Federal employees health benefits program utilization of hospital services. Does that group of charts go with the paper?

Dr. ESSELSTYN. Yes, sir, it does.

The CHAIRMAN. Then you really had in mind both of them?

Dr. ESSELSTYN. Yes, sir.

The CHAIRMAN. Very well, they will both be included along with your statement.

Mr. Huot, have you any questions?

Mr. HUOT. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Younger.

Mr. YOUNGER. I have just one question, Mr. Chairman.

I think you brought in a new angle on this insurance. Just what do you mean by an outpatient ambulatory facility?

Dr. ESSELSTYN. I think traditionally over the years the hospitals of the country have been primarily interested in and concerned with the care of the horizontal patient. I think what we are talking about is the patient who does not have to be hospitalized, but who is in need of ambulatory care.

Mr. YOUNGER. Do you have in mind a semihospital, or do you have in mind just a clinic where a group of doctors get together and practice?

Dr. ESSELSTYN. I think this can be either way. Clinics can be physically attached to a hospital but separately administered, or clinics can be free standing, by themselves, and serve a great purpose in areas where there are not hospitals.

Mr. YOUNGER. It would seem to me that extension of H.R. 2984, I believe it is, would provide the funds for your so-called outpatient hospital, but it is a different form, as I understand, from a care facility that would need insurance or guarantees.

Dr. ESSELSTYN. The kind of buildings that we are talking about are not covered under Hill-Burton. Is that what you mean?

Mr. YOUNGER. This isn't an extension of the Hill-Burton. This is an extension of the medical facilities bill.

Dr. ESSELSTYN. I am not familiar with that. I thought it had to do with research.

Dr. DEARING. Mr. Chairman, perhaps I can clarify this for Mr. Younger.

The Hill-Burton Act when originally conceived, before it ever became the Hill-Burton Act and when it was proposed by the administration shortly after the war, proposed, in addition to grants for the construction of hospital facilities, to provide grants for separate diagnostic and treatment centers for ambulatory patients which would be located in areas where it would not be necessary to build hospitals. This provision was not accepted by the Congress, and the Hill-Burton Act was limited to grants for the construction of hospitals. Later, on the recommendation of this committee, the act was amended to provide for diagnostic and treatment facilities for ambulatory patients but still related to hospitals only.

The group practice facilities that we are supporting—for mortgage insurance, mortgage guarantees, and loans—would not necessarily be related to hospitals, but they could be for groups of doctors serving plans on a prepayment basis and serving the subscribers, the enrollees in the plans, who prepay for their medical care, to establish and provide service independent of hospitals. The administration's proposal of 20 years ago has never been implemented and this would be a step toward doing that.

Mr. YOUNGER. In our district, we have a lot of those facilities where the doctors practice as a group, the different specialists. So far as I know, no one has ever had any trouble about getting financing. I am surprised at what you say about Kaiser, because they have facilities and have never said to me at any time, and I have been in contact with them a lot, that they have had any trouble in getting money. They have just built a lot of fine hospitals. But I will get in touch with them and find out.

Dr. DEARING. Mr. Chairman, 10 or 11 years ago, I believe in 1954, in hearings before this committee, Mr. Kaiser, himself, stated that they had had difficulty, that the health plan had had difficulty in getting financing, that they had only been able to get funding under his personal note, his endorsement, and that their facilities had not been able to keep pace with the desired enrollment, and that they had had to close enrollment from time to time until they could get more facilities. This situation prevails today in that in some communities, parts of the northern and southern California areas which Kaiser serves, they have enrollments closed because they are blind on facilities. The Kaiser Foundation health plan informed us that they anticipated seeking financing for construction of facilities in a 5-year program from now to 1970 in the neighborhood of about \$25 million. This is not to say that they can't get any of it, but this is the extent of their need and this has been their history.

Mr. Kaiser, himself, reported this to this committee 10 years ago.

Mr. YOUNGER. I am not talking about 10 years ago. But things have changed a lot of that organization since that time.

That is all, Mr. Chairman.

The CHAIRMAN. Mr. Mackay.

Mr. MACKAY. No questions.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Gilligan.

Mr. GILLIGAN. Thank you, Mr. Chairman.

The question which has arisen in connection with this proposed legislation time and again, Doctor, is in connection with the problem just mentioned by Mr. Younger, about real need for this kind of financing.

On page 6 of your statement you make reference to the fact, in paragraph 5, that there have been failures recorded, particularly in the early years. This record provides an added risk which has not been overlooked by loaning agencies.

First, can you be more specific, either now or by supplementary submissions to this committee, in terms of how many such failures have been recorded and where, and whether or not they were due to financial difficulties or to some other sort of difficulties?

Dr. ESSELSTYN. I can give you a specific instance of one that failed 6 months ago because of lack of financing called the Rip Van Winkle Clinic, in upstate New York.

Mr. GILLIGAN. Are there others than that in the Nation?

Dr. ESSELSTYN. There are many in the Nation. I would be glad to supply it, if I may, for the record later.

Mr. GILLIGAN. I think it would be helpful for the committee, because this question recurs of being able to document a real need.

Dr. ESSELSTYN. It is a very real fact, the fact about financial failures.

(The statement follows:)

GROUP HEALTH ASSOCIATION OF AMERICA, INC.,
Washington, D.C., March 16, 1965.

Hon. OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee, Longworth House
Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: Examples of failures and delays in providing and equipping facilities for group practice resulting from lack of financing, which the committee requested in the course of hearings on H.R. 2987, are attached. There are statements regarding the following eight locations:

Jefferson Health Foundation, Inc., Birmingham, Ala.

The Medical Foundation of Bellaire, Bellaire, Ohio.

The Golden Clinic, Elkins, W. Va.

Monongahela Valley Association of Health Centers, Inc., Fairmont, W. Va.

Miners Clinics, Inc., New Kensington, Pa.

East Point Health Center, Baltimore, Md.

Health Insurance Plan of Greater New York, New York, N.Y.

Group Health Association, Inc., Washington, D.C.

I should like to state for the record that:

(1) Group practice has been cited as an essential step toward the efficient organization of medical care to provide the benefits of medical research and modern medicine and to make the best use of skilled medical manpower by President Truman's Commission on Health Needs of the Nation, by President Eisenhower's Secretary of HEW, Arthur Flemming, and by Presidents Kennedy and Johnson.

(2) Group health plans, which combine group practice with prepayment to spread and systematize payment for the costs of care have the essential distinguishing feature that they actually provide the medical care and are responsible for its quality and availability. This is completely different from the Blue Cross-Blue Shield and insurance company prepayment plans, which simply pay the provider or reimburse the subscriber for part or all of hospital and certain medical care costs out of funds accumulated from premiums.

(3) The difficulties experienced by group practice plans in securing financing for the capital costs of facilities, because of the special nature of both the plans and the facilities, continue to be a serious factor in retarding the needed growth of group practice plans.

Very truly yours,

W. P. DEARING, M.D.,
Executive Director.

STATEMENT OF ADMINISTRATOR, JEFFERSON HEALTH FOUNDATION, INC.,
BIRMINGHAM, ALA.

Here in Alabama the Jefferson Health Foundation, Inc., a nonprofit corporation established for the purpose of providing medical care through group practice, has recently constructed two clinics. There was considerable difficulty and agonizing trials to obtain loans for this purpose. It was practically impossible to explain to banks as well as all other types of lending agencies our organizational structure. It seems that when something is being built for profit by an individual physician or physicians, they quickly visualize huge incomes which will permit amortization easily, and thereby more satisfactorily guaranteeing the loan.

In Jasper, Ala., numerous insurance companies, banks, and others were contacted with plans, specifications, completion of many forms but finally a turndown was always received. These lending agencies were located in various parts of the country. It was only because one of the physicians in the group in Jasper happened to be a longtime resident in the community and well-known by a local savings and loan association that we were finally able to negotiate a loan. This was at a rate of $6\frac{1}{2}$ percent.

In Birmingham we had a similar experience attempting to obtain a loan through various insurance companies and others. Finally, due to a personal contact with a local mortgage firm we were able to secure a loan. Their representative, however, made trips to Cincinnati, Ohio, New York City, and no telling how many other places, in an attempt to obtain financing. This is at a rate of $5\frac{3}{4}$ percent. Only their perseverance finally permitted securing of the loan.

Obtaining these funds, however, delayed the construction, and naturally higher rates of interest affect medical care cost, also. An attempt was made to secure money from the Small Business Administration. They would lend money to an individual physician or a group of physicians operating for profit, we were told, but not an organization operating on a nonprofit basis.

In the future, we hope to construct an additional clinic in an area that greatly needs such a building. We will probably run into the same difficulty as heretofore. Since medical care is so necessary, decent modern facilities are needed so badly, and medical care is so costly, it would seem only justifiable that nonprofit group practice organizations should be able to obtain loans at reasonable rates of interest through an agency of the Federal Government.

STATEMENT OF SECRETARY-TREASURER, THE MEDICAL FOUNDATION OF BELLAIRE,
BELLAIRE, OHIO

Our experience has been that nonprofit, group practice programs cannot normally borrow from commercial sources.

We learned then, that commercial banks and insurance companies are not interested in investing in programs like ours. The reason, we were told, is that a group practice clinic building is such a narrowly circumscribed, one-purpose building, that in the event we were to default, and the bank or insurance company had to take over the property it would be exceedingly difficult to find another user. The alleged danger to the commercial lender is enhanced by two additional factors:

1. We are a nonprofit organization. Although at that time (1957-58), the foundation had not yet officially been incorporated, our program was owned and operated on a "trust" basis by the medical group. Nevertheless, we were considered to be working within a nonprofit framework. (The foundation was actually incorporated in October 1958). Apparently, commercial banks and insurance companies frequently consider nonprofit organizations not to be particularly good risks for investments.

2. We operate in a small town, semirural area. The Harrisville Clinic is in a completely rural area, which, in eyes of the lenders, made the one-purpose nature of the building even more dangerous from the point of view of investment. This

was true even though we showed that the clinic is within reach of 15,000 to 20,000 people living in the country and in towns of 500 to 3,000, within a radius of about 10 miles.

In 1961 and 1962 we accumulated some reserves in our building fund. It was our understanding at that time that we would probably have to have about one-third in cash of the planned construction and equipment cost of any facility, in order to borrow the rest from a commercial institution. The only realistic source was again the Nationwide Insurance Co., but even here some question existed, because for our \$45,000 mortgage for the Harrisville Clinic we were required to have our physicians personally sign the note. The doctors involved were reluctant enough to sign a \$45,000 note. One could hardly expect them to sign a note of the size we would be considering in building a central clinic in Bellaire; namely, something in the range of \$500,000 to \$800,000.

Because our hospital privileges fight became so urgent, and we became involved in legal action to which we have committed our small building fund, these problems became irrelevant.

However, we have no reason to believe that the difficulties which existed at the time of our borrowing money for the Harrisville Clinic, and which existed throughout the following years, are at all alleviated today.

STATEMENT OF ADMINISTRATOR, THE GOLDEN CLINIC, ELKINS, W. VA.

On several occasions in the past few years we have attempted to borrow moneys from banks and commercial houses for the purpose of expanding facilities and increasing services. We have not been able to obtain the moneys from these sources because the banks do not look upon nonprofit clinics favorably as a sound loan, in view of the other more secure loans that they can make.

We were successful in obtaining a loan to match our Hill-Burton grant from an insurance company in the amount of \$400,000, but at a $6\frac{1}{4}$ percent interest rate on a relatively short-term loan. It was necessary that many contacts be made and much time elapsed before the loan could be approved and obtained.

We were fortunate to find a source and undoubtedly many organizations fail to obtain funds because of the scarcity of loan institutions interested in making loans of this type. These factors tremendously curtail the development of clinics due to their inability to find sufficient and timely funds for expansion of facilities and services.

STATEMENT OF ADMINISTRATOR, MONONGAHELA VALLEY ASSOCIATION OF HEALTH CENTERS, INC., FAIRMONT, W. VA.

The Monongahela Valley Association of Health Centers is a chartered West Virginia nonprofit corporation with exemption from both State income tax and Federal income tax. It was organized in February 1958 by citizens from various walks of life in order to provide modern outpatient facilities for the adequate medical and health services required by the people of this area and to furnish office space for a quality-oriented medical group. It presently operates a modern clinical laboratory, X-ray department, electrocardiography, basal metabolism, physical therapy, medical-social service work, pulmonary function laboratory and blood-gas analysis unit, as well as offering office space and other facilities for a medical group of more than 10 physicians. The association is run by a board of directors who receive no remuneration whatsoever for their services which require, on the average, several days per month. The original organizers of the association and the present board of directors include ministers from several denominations, professors from State and private colleges, housewives, social workers, public, business and labor officials, and persons generally associated with civic responsibility and activity in this area. The association operates, of course, on a nonprofit basis and all accumulation at the end of each year since the beginning has been put into a building fund with the single principal goal of the association being that a modern clinical facility could be built in the Fairmont area to house all of the services.

Starting about 1960, the association began seeking financing for the building of such an outpatient clinic facility in Fairmont. Various commercial insurance companies were contacted and several of them sent representatives into the area to investigate the association. Trips were made by us to the leading commercial banks in Pittsburgh and financial reports and other data were presented in con-

nection with the need for financial backing for such a facility. Savings and loan and commercial banks elsewhere in southwestern Pennsylvania and in northern West Virginia were contacted and dealt with in the 2 years, 1960-62. Leading "money brokers" in this area were contacted and talked with, and in some cases, referred us to various insurance companies and other financial institutions several of which came into the area and reviewed our present facilities and plans for the future.

In all cases, financing on a commercial basis was refused on the basis that we were a nonprofit organization even though we offered to put up in cash and securities, 50 percent of the equity for a carefully planned outpatient clinic facility. The long delay created by these unsuccessful efforts to secure financing prevented the recruiting of many physicians badly needed in the area and to this day have restricted the activities of the association in offering high quality health services to the general public.

It was not until 1963 that we were able to secure a financing agreement executed with two local banks and supported by a Pittsburgh bank on a joint basis and we were able to secure financing on a 50 percent basis over a 10-year period for a building valued in advance at \$900,000. Actually, the association facility, which will be finally occupied next month, essentially due to the long delay in securing financing, will with its equipment cost \$1,150,000. In effect, therefore, the financing amounts to considerably below 40 percent of the actual cost of the facility.

I think it is important to note that every financial institution we talked with were impressed with our fiscal and other controls as an organization and that the single statement made in denying us support financially was that we were "a nonprofit organization." In several cases we were offered financing despite this situation if the doctors occupying the facility would sign notes as sureties to "assure" the bank or insurance company of a kind of moneymaking or profit basis to the activity. In every case that latter proposal was refused since the organization has always functioned on a bona-fide nonprofit foundation.

STATEMENT OF ADMINISTRATOR, MINERS CLINICS, INC., NEW KENSINGTON, PA.

The task of getting financing to put up a headquarters clinic for our organization was long, involved and disappointing. It was costly in terms of time and energy.

Negotiations started officially in October 1958 and culminated with a loan approved by Nationwide Insurance Co. for \$340,000 in January 1961. It was a 6-percent loan based on a first mortgage with a loan fee of \$1,700 and other costs.

The following sources were approached with correspondence measuring approximately 3 inches in thickness: Small Business Administration; D'Orazi Investment Co., Sacramento, Calif.; the 65 Security Plan, New York; various insurance companies; Insurance agencies; Mortgage companies; Banks; Real estate companies.

Even in the case of Nationwide Insurance, they first turned down the loan and subsequently accepted and approved it.

We hope that this brief report shows the great expenditure of time and energy necessary to get financing. Remember that financiers we approached were dealing with an economically successful group practice with demonstrated earning power and obvious potential.

In my own few years of business experience, including hospital administration, I have not encountered such a disappointing reaction as our own situation here portrayed.

STATEMENT OF MEDICAL DIRECTOR, EAST POINT HEALTH CENTER, BALTIMORE, MD.

We have been operating a group practice, nonprofit medical center since 1957. It became quite apparent by 1960 that the limited area (1,500 square feet) was rather inadequate to service our enrolled members. We therefore sought property on which we could perhaps build a larger more complete medical center. The property was found and six of the doctors invested a down payment. We then set out to obtain funds to finance the construction. We soon found that limited moneys were available and then only if the doctors took total liabilities on the loan.

After 3 years of searching and frequent negotiations we were able to secure a loan for construction. However, we now find that there is very little, if anything, left for operating capital. We are, at present, still struggling with the problem.

Additional community and blue collar groups have approached our medical group to establish group medical centers in other areas. We have discussed our mutual problems and find that construction costs for a new building and immediate operating and contingency costs represent difficult problems to resolve.

STATEMENT OF PRESIDENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK,
NEW YORK, N.Y.

The Health Insurance Plan of Greater New York, after great difficulty in securing facilities financing in its early days, 1945 to 1955, is now able to secure facilities financing, but only up to one-third the capital cost. Consequently, the insurance plan assets must carry the other two-thirds of the construction costs until liquidated.

This means that the building of needed facilities for the plan's medical groups has been delayed for several years. Enactment of H.R. 2897 would greatly speed up construction of the 7 needed facilities: 2 in fiscal year 1966 and 5 in the succeeding 2 or 3 years.

STATEMENT OF EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION, INC.,
WASHINGTON, D.C.

Group Health Association, Inc., is a nonprofit, consumer-owned medical service cooperative with membership of more than 55,000 persons in the Washington, D.C. metropolitan area. It provides prepaid comprehensive medical care to its members through group practice of its medical staff in its own facilities for ambulatory care and in community hospitals when members require hospitalization for treatment.

It was founded in 1937 and was among the pioneers in this method of providing prepaid medical care, in which the plan undertakes actually to provide the care rather than merely paying for it. As a pioneer, it was vigorously opposed by organized medicine. GHA was finally sustained in a historic decision by the U.S. Supreme Court, which found the American Medical Association and the D.C. Medical Society guilty of restrictive and monopolistic practices.

Group Health Association of D.C. in December, 1962, occupied its new facility at 2121 Pennsylvania Ave., construction of which was started in September, 1961. The story of frustration and delay in securing financing with consequent reduced efficiency of service and limitation of enrollment illustrates the handicaps which are restricting and retarding the growth of prepaid group practice today.

In the early 1950's, the health cooperative laid a building assessment on its members for the purchase of the old Arlington Hotel on Vermont Avenue in which to consolidate its previously dispersed medical facilities and improve the efficiency and convenience of medical service. By the late 1950's, GHA's enrollment and the progress of medicine had outgrown this facility; more and better space was urgently needed.

The Association's board of directors, in December, 1959, made the decision to act. After studying possible sites, the board decided in June to locate near George Washington Hospital and in July selected the present site. The location was not only available and suitable, but also a major national life insurance company had already indicated its interest in financing the construction of a medical arts building there.

One of Washington's outstanding realtors has handled GHA's building management over the years and in September 1960 was instructed to negotiate for the construction of the 2121 Pennsylvania Avenue building. He proceeded with negotiations and in January 1961 was authorized to sign a lease-purchase agreement on the basis of informal indications from a senior vice-president of the insurance company of a construction loan of \$2.25 million for a medical arts building.

When he attempted to act on this authorization, he was advised not to apply for the insurance company loan because the application would be denied. The agent advised GHA he would contact other investment sources.

He worked on the problem for several months and advised GHA that "The principal difficulties were: (1) Group Health's lack of reserve financial strength and the fact that some operating deficits have occurred in past years; (2) some opposition by insurance companies to financing this type of operation, which is

in competition to the sale of health and medical insurance; (3) a limit of 6 percent interest on insurance company lending in the District of Columbia, whereas they can obtain higher rates in other areas.

From March to August 1961 the realtor sought financing. This was finally secured in a \$1.91 million loan from a local savings and loan association.

Mr. GILLIGAN. One further suggestion was made and alluded to a second time in the testimony before the committee, and that was the availability of Small Business Administration loans to practitioners in medicine, and that the loan funds and mortgage guarantees proposed in this legislation were really unnecessary because the people who could not get conventional financing could go to the Small Business Administration. I have seen records come through my office of individual physicians getting a Small Business Administration loan. Is this really an alternative? Is it unsatisfactory for some reason?

Dr. ESSELSTYN. It is an alternative, (B) it has a high interest rate, and, (C) it is not available to nonprofit groups. It is only available to profitmaking groups.

Mr. GILLIGAN. That was the point that I suspected was so, but I did not know enough about the regulations of the Small Business Administration to be able to document it.

Thank you, sir.

The CHAIRMAN. Dr. Carter.

Mr. CARTER. Doctor, I believe you were director of the Rip Van Winkle Clinic in New York, were you?

Dr. ESSELSTYN. Yes, sir, I was.

Mr. CARTER. That was a group practice unit, was it?

Dr. ESSELSTYN. That is right.

Mr. CARTER. You had a prepayment plan?

Dr. ESSELSTYN. Part of our income was from a prepayment plan.

Mr. CARTER. Did you say your institution failed?

Dr. ESSELSTYN. Yes, we did.

Mr. CARTER. Was that because of a lack of Federal financing or the nature of group practice within itself, in the group prepayment plan?

Dr. ESSELSTYN. In the last year of operation, we provided some \$91,000 worth of free care to patients who we could not get on welfare and at the same time our accounts receivable went up over \$122,000. Many of these patients probably should not have been billed. This was our undoing.

Mr. CARTER. I noticed you mentioned Appalachia. I suppose you are familiar with Appalachia?

Dr. ESSELSTYN. Well, I have been to Harlan, Middlesboro, Whitesburg, Hazard, McDowell, Pikeville, Beckley, Mann, and Williamson.

Mr. CARTER. I believe you state here that directors of money loaning institutions such as commercial banks look with disfavor upon loans to groups who want to go into practice, is that right?

Dr. ESSELSTYN. Yes, sir.

Mr. CARTER. Is that true?

Dr. ESSELSTYN. It is true in many cases.

Mr. CARTER. In our county in Appalachia we have two groups. Both of them have been financed by local banks. It happens that I am a director of one of the banks and a member of the medical society. But, nevertheless, contrary to what you say, we want to finance worthwhile projects to help the people as much as we can.

Dr. ESSELSTYN. I think it is a very fortunate situation, and certainly there would be no need there for this bill.

Mr. CARTER. But we realize that in certain areas there is need for this, and where human efforts are made to help people, certainly where there is need, it should be covered. But where financing is available from local services, that should be done.

Dr. ESSELSTYN. I think we all agree, Dr. Carter, and I think the bill spells this out very specifically.

Mr. CARTER. That is all, Mr. Chairman.

Thank you.

The CHAIRMAN. I did not get your comment a while ago, Doctor, about the reason for the failure of the clinic you referred to.

Dr. ESSELSTYN. It was simply when our credit did not stand up. When the sheriff got on the front door, it was a very easy decision to make. We gave away in our last year of operation over \$210,000 worth of medical services for which we were never paid.

The CHAIRMAN. What was the source of the funds for the Rip Van Winkle Clinic?

Dr. ESSELSTYN. The initial financing of the clinic came from foundations, from gifts from patients, from other agencies.

The CHAIRMAN. Were there gifts from these sources that kept it going?

Dr. ESSELSTYN. That is right. It was a demonstration program.

The CHAIRMAN. Rather elaborate arrangements and services were provided, too?

Dr. ESSELSTYN. Anything but. It was comprehensive care, but it was on a very homespun basis.

The CHAIRMAN. A homespun basis in that the charges were homespun, that they were not very much?

Dr. ESSELSTYN. That is right.

The CHAIRMAN. But the facilities, themselves, and the care were rather elaborate as a demonstration project?

Dr. ESSELSTYN. I would not say it was elaborate, Mr. Chairman, I would say it was thorough. I would say it practiced medicine of high quality. But I would not say it was elaborate in any sense of the word. The facilities were completely functional and very plain.

The CHAIRMAN. When the foundations refrained from contributing any more and the donations referred to were not forthcoming is when you started having your trouble, was it not?

Dr. ESSELSTYN. That is right.

The CHAIRMAN. The reason I asked these questions was not to reflect at all on the operation of the project, or criticize it at all, but to try to figure out how that is an example of what is proposed here. Are you indicating now that we initiate a program that will have for its purposes the setting up of facilities for purposes doomed to failure?

Dr. ESSELSTYN. Not in the slightest. It is simply that if we had been able to get started in the kind of area in which we were working, and did not have to have to spend as much in the way of amortization of our capital in addition to the money which we were given, we would have been in a much stronger situation. There are many areas in the country, Mr. Chairman, as I am sure you know, where there is sparse population and where the economic level is low. In Columbia County, when we started, the median family income was \$2,399. It subsequently rose to about \$5,000. The county had the third oldest population of any county in New York State. It is interesting to note that of the accounts receivable, 72 percent were for the services delivered to patients over 65.

The CHAIRMAN. That is very appealing to me, and I think you and others are to be commended for your advocacy of some way of meeting those needs. I still don't see, from what you have explained here, how this is going to meet the needs. The mere fact that you put some brick and mortar into a place and develop it does not mean that it will be a successful operation.

Dr. ESSELSTYN. I don't say that this bill would have saved the Rip Van Winkle Clinic. The Rip Van Winkle Clinic only came into this discussion because somebody asked for an example of a group that had failed for financial reasons, and this I pointed out.

The CHAIRMAN. I know, but that is the reason that though I did not intend to take the time I decided to do so, in connection with this program here. It seems to me that we ought to be thinking about the kind of programs that are going to be successful, and not the kind of programs that we are going to get ready for here that we admit are questionable and can't succeed. I don't want to enter into a program if that is the kind it is going to be, loaning Government money out of the Treasury of the United States, with cheap interest on it, and then indicate to everybody that we don't expect to get it back. I have been through all of that that I want to go through, with loans to certain railroads in the country, who make certain promises and that have never been able to carry them out.

Mr. CARTER. Will the distinguished gentleman yield?

The CHAIRMAN. This is a mortgage guarantee by the Government and is the same thing.

I will yield.

Mr. CARTER. This, in itself, is a comparison of group practice with prepayment plans and practice of private physicians in groups using individual initiative. I believe he states that in Columbia County, N.Y., the average income was \$2,399. In our county, I believe the average income is less than \$1,400 per capita. There are two clinics in our county. We do not have the prepayment plans, but they are quite successful. At the same time, we have a hospital in a small community which is quite successful, and from that hospital, so far as I know, and I have been chief of staff of that hospital for quite a while, not a patient was ever turned away. It seems quite a contrast.

As our distinguished chairman has said, this casts doubt upon the continuation of group practice with prepayment plans. This money might be used as subsidies.

Thank you, sir.

Dr. ESSELSTYN. I would like to point out if I may, Mr. Chairman, that less than 1,000 patients were on a prepaid basis at the Rip Van Winkle Clinic. Had they been able to afford the premiums necessary to be on a full-time basis with prepaid care, there would be no problem.

But we are not here to really talk about Columbia County, because there are certain areas in the country where there are existing circumstances that just don't support this kind of a thing. The areas where we can be effective are areas such as Detroit, Rhode Island, Baltimore, and the many areas around the country that can support this kind of a program.

In this setting, I think this kind of a program merits the very best consideration that can be given because it can provide high-quality medical care at low cost.

Mr. CARTER. And you need this worse in these rich communities than we do in Appalachia, is that right?

Dr. ESSELSTYN. I did not get that. What was that?

Mr. CARTER. You need these subsidies in these rich areas that you mentioned, Baltimore, Detroit, and so forth, rather than in areas where the per capita income is less than one-half of what you mentioned, such as Columbia, N.Y.

Dr. ESSELSTYN. We are only speaking of places where private funds are not available. If private funds are available in these areas, then there is no need of this kind of utilization. But if you have ever tried to raise funds for this kind of a program, I am sure you would see the difficulty associated with it.

Mr. CARTER. Sir, I have tried to raise funds.

Dr. ESSELSTYN. For a prepaid program?

Mr. CARTER. Not for that, but for a private clinic.

The CHAIRMAN. We might as well acknowledge the issue involved here. We have been talking around the fringes of it and arguing about whether the funds are available, with most of my colleagues thinking it was primarily for medical groups to get together and organize a group practice facility. In my judgment, this program is not primarily intended for that kind of clinic. I think the facts here are that those who are sponsoring and proposing this are doing so on the basis of organizing and expanding the prepayment type of clinical and medical treatment program, and to operate it on that basis.

The way I see it at this time, if we will once recognize what the issue is and what it is going to be, I am inclined to agree with many of the witnesses who have appeared here that there are not funds available in a conventional way for that kind of a program. As a matter of fact, the only kind of programs of that nature that I know of that have been highly successful generally have been the burial organizations. If you get into one of those organizations, you get into one that is stable. Everyone knows that they are going to die. There is not anybody who will argue with you about that. So, regardless of how little income they have, or what the average might be in a community, you go to any funeral home that has organized one of these and you will see that they have their membership and it is sustained. As long as you can have sustained membership, you are going to have a successful program.

This is a program to permit certain groups, private groups or organizations, to go out and organize this kind of a program. This committee and the Congress will have to decide whether we want to put up funds from the Federal Government to establish this kind of a program. That is the way I see it.

If I have misstated anything, Doctor, I wish you would correct me.

Dr. ESSELSTYN. No. I think the Government could be of tremendous help in doing this.

The CHAIRMAN. I am not talking about what the Government can or cannot do. I am trying to state what I think is the objective here.

Dr. ESSELSTYN. Our interest in this bill is seeing this kind of a program aided and abetted to get off the ground.

The CHAIRMAN. The purpose of this legislation is to promote a group-type, prepayment-plan program in order that it can be organized and put into effect in certain of these congested or highly populated areas.

Dr. ESSELSTYN. This is the particular interest that the Group Health Association of America has in supporting this bill.

The CHAIRMAN. And that is what is largely proposed here, isn't it?

Dr. ESSELSTYN. That is what we are emphasizing.

The CHAIRMAN. And I think that is the issue. I think we all, regardless of the questions we have asked about the need for this, and whether the funds are available under the conditions mentioned, realize that. Under the conditions that Dr. Esselstyn has just given to us, I think the record is very clear what it is for. We should not have too much difficulty in making up our minds what we want to do, since we understand what is proposed.

Doctor, thank you very much, all of you, for coming here to help clarify a situation which has been in the forefront of this discussion since the early part of the week.

Dr. ESSELSTYN. Thank you.

The CHAIRMAN. Dr. Newman, did you intend to supply additional statements?

Dr. NEWMAN. Only in the event that there were questions pertaining to dentistry, Mr. Chairman.

The CHAIRMAN. You have no further comment, Doctor?

Dr. NEWMAN. No, Mr. Chairman; I was only here in case questions would arise pertaining to dentistry, since this bill does name dentistry in addition to medicine.

The CHAIRMAN. Thank you very much.

Dr. NEWMAN. You are welcome.

The CHAIRMAN. Is Mr. Charles Whittemore here?

Mr. HUOT. I am advised that he cannot come today. He is supposed to check back with me to see if he can get on later.

The CHAIRMAN. Mr. Charles Whittemore is director of the Community Health Facilities Office of Economic Opportunity, Canal Street, Manchester, N.H.

I regret that we were unable to get to Mr. Whittemore while he was here. He had to leave. If he desires, he may file a statement for the record.

The CHAIRMAN. The next witness will be Dr. Edwin P. Jordan, M.D.

**STATEMENT OF EDWIN P. JORDAN, M.D., EXECUTIVE DIRECTOR,
AMERICAN ASSOCIATION OF MEDICAL CLINICS, CHARLOTTES-
VILLE, VA.**

The CHAIRMAN. Will you identify yourself, please, sir.

Dr. JORDAN. Thank you, Mr. Chairman.

My name is Edwin P. Jordan. I am a physician serving as executive director of the American Association of Medical Clinics, which is a voluntary society of private medical clinics with over 160 members in the United States and three in Canada, maintaining offices in Charlottesville, Va.

On behalf of the association, I wish to express appreciation for this opportunity of appearing in support of this legislation and to urge a few changes in the wording of the bill.

I might have written this somewhat differently had I been aware of the kind of testimony presented earlier. I thought the discussion

was to be on group practice facilities and it turned out to be largely on prepaid medical care.

There was insufficient time for the remarks I am about to make to be approved by the officers and trustees of the association or the association as a whole, but I believe that they do represent in general the views of the association, as well as of myself.

This legislation, if enacted with a few revisions, will do no harm to anyone, in my opinion, and will on the contrary make it possible for some physicians who would like to engage in group practice, but are currently unable to do so, to take such action. It will also make it possible for some group practice organizations to expand more rapidly to better serve their patients.

In this connection I might mention that near the end of World War II a survey of physicians then in military service, conducted jointly by the military and the American Medical Association, was made. Of those who replied over 50 percent indicated that they would like to engage in group practice on their return to civilian life. Of course, nothing like this number actually did so, in part because one of the obstacles was the availability of facilities, which are costly and difficult to provide.

Several changes in the wording of the bill would strengthen it, in my judgment, since its effectiveness will depend largely on its administrative implementation and both the professional and fiscal responsibility of those receiving mortgage insurance or loans should be carefully explored in each instance.

I should like to expand briefly on this topic. There are a number of varieties of group practice including groups of general practitioners and specialists and groups which are composed of general practitioners and specialists with or without dentists. There is also great variation in size. Some groups engage in prepayment plans and some do not. Some are in rural areas, some in cities and some in suburbs. Some are nonprofit organizations, but more are partnerships, associations, or professional corporations organized under recently enacted State laws.

The fiscal and professional success of these different varieties of medical groups, in our experience, is not directly related to any of these variables, even size of the group. While there are means of prejudging and evaluating the chances for professional and fiscal success of a group of doctors, and probably dentists, these cannot be measured by definition, but only by careful evaluation of the many factors involved in each instance.

Hence, I believe it would be highly unwise to include in the bill statements which would discriminate between one form of group practice and another and it would be better to leave the decision on approval for mortgage insurance or loan at the administrative level. Although this throws a burden on administration, properly advised judgment can be reasonably accurate.

Therefore, I would urge the deletion of the following:

On page 2, line 6, "and of facilitating * * *" to line 9, "* * * members or subscribers"; and on the same page, line 17, "and those sponsored * * *" to line 18, "* * * nonprofit organizations."

I am troubled by the definitions of "group practice unit or organization", beginning on page 18. These definitions are narrow and restrictive and so far as I can tell nothing would be lost by deleting sections 4 and 5 on pages 18, 19, and the first two lines on page 20,

since all of them could be considered covered under section 3 on page 18. To include these sections, I believe, would be unjustifiably discriminatory as well as unnecessary.

I should also like to comment on section 907(a) on page 16, where it might be helpful to broaden the paragraph by adding after the word "provide", on line 1 of page 17 the words "or obtain".

The reason for this suggestion is that I am dubious that the Surgeon General's Office has available all of the information that may sometimes be needed and it might be possible to obtain technical assistance from our association, the American Institute of Architects with whom we are working, or others under certain circumstances.

Finally, I should like to compliment the committee for holding hearings on this important bill and to express my willingness—and I am sure I can speak also for the AAMC on this—to answer any questions we can at this time or in the future.

Thank you.

The CHAIRMAN. Doctor, thank you very much for your statement and your suggestions.

Are there any questions?

Mr. Younger?

Mr. YOUNGER. No questions, Mr. Chairman.

The CHAIRMAN. We appreciate having your statement. I just have a hunch, as we say down in our part of the country, that if your suggestions are approved, it will take a lot of the steam out of this proposal. I think the enthusiasm from a lot of sources will probably be lost.

I noticed you have submitted two pamphlets which we will be glad to receive for our files, for the benefit and information of the committee.

Thank you very much.

Dr. JORDAN. May I say one more thing, Mr. Harris?

The CHAIRMAN. Yes.

Dr. JORDAN. I put this down, because I thought I might be asked, and since I was not asked, I would like to say it anyway.

The CHAIRMAN. I am sorry we did not anticipate you.

Dr. JORDAN. I mentioned that there are criteria for judging professional and fiscal responsibility in the guaranteeing of mortgage loans, or making direct loans. Some of these criteria which should be applied are the medical leadership, good professional qualifications, good business management, attention to long-range goals, avoidance of overexpansion, willingness to pay for building and other expenses, geographical location—that is the drawing area of patients—common philosophy of the physicians, minimal friction between them, ability to work together, agreement that advantages of group practice outweigh the disadvantages, pooling of income and redistribution under prearranged plan, availability of hospital facilities, proper design of building, flow of patients, medical records, laboratory, X-ray, et cetera, parking space available, and public transportation.

The above are not necessarily in order of importance and do not list all of the important factors. What is desirable for one group in one place may not apply to another group located elsewhere. These things can be evaluated, but it takes a little skill to do it, I think.

Mr. NELSEN. Mr. Chairman.

The CHAIRMAN. Mr. Nelsen.

Mr. NELSEN. Earlier some testimony presented indications of failure of one of these clinics, but by and large it seems to me the

testimony would indicate that funds to start these group practice units is a problem. But once they have been started, is there a history of failures, any extensive history of failures?

Dr. JORDAN. Not extensive failures, but there are failures. I have visited groups just before they have failed and visited the remains, if you want to call them that, afterward. I think we have very good information as to what causes failures. There are several different factors involved in that. One time I thought the small groups were more likely to fail than the large ones. However, some quite large ones have also failed, basically because their medical leadership was not adequate.

Mr. NELSEN. In rural communities, I presume the small community would have some difficulty supporting a group practice unit. Of course, in the rural communities we are very concerned about the availability of a doctor. But I presume your group practice unit would have to be in large population centers to support the unit. Is that not also a possibility?

Dr. JORDAN. No; that is not true, sir. This is a very interesting phenomenon. Some extremely large clinics, as well as small ones, are in very small communities. There are 45 doctors in a community of 9,000, for example. If any of you are from Pennsylvania, you doubtless know of that one. Then there is one in Texas with 80 or 90, in a very small town.

There is one in northern Wisconsin with 55 doctors in a town of 15,000 or 20,000. This is true all over. Actually, if the medicine they practice is good medicine, the principle of the better mousetrap works and people come from long distances. Of course, the classic example is the Mayo Clinic where people come from all over the world. But there are many other examples of a similar nature, though not with such wide drawing areas.

Mr. NELSEN. Thank you.

Mr. CARTER. Mr. Chairman?

The CHAIRMAN. Dr. Carter.

Mr. CARTER. Are your clinics composed, or are the organizations composed principally of physicians?

Dr. JORDAN. Entirely, sir. Except they have a business manager, most of them.

Mr. CARTER. In your case you don't have nonprofit groups which hire the physicians?

Dr. JORDAN. Not which hire physicians. There are a few of them that are organized as nonprofit foundations. But the physicians have the control, so to speak, of the medical practice.

Mr. CARTER. And the more the clinic earns the more money they earn in turn, as individuals?

Dr. JORDAN. I am not sure I understand your question correctly, Dr. Carter.

Mr. CARTER. Where we have groups which are incorporated and, as groups, employ physicians, the physicians, as a usual thing, are on fixed salary. In that way they don't have much inclination or desire to go out and increase their practice, to get more physicians. But as members of a group or as an integral part of a clinic they would have such a desire.

Is that not true?

Dr. JORDAN. Yes.

Mr. CARTER. And as a result of such desire, the effort, the individual enterprise, and so on, of these clinics served have flourished.

Dr. JORDAN. Perhaps I can answer your question best by saying that most clinics which have been in existence for quite a long time find that they can not wholly remove incentive from the life of the physician. It is partly removed in most groups, but not completely. I sometimes call it the Three Musketeers philosophy.

Mr. NELSEN. Will the gentleman yield at that point?

Mr. CARTER. Yes, sir.

Mr. NELSEN. In the bill, on page 2, reference is made to a sort of preference to group practice interests or organizations, particularly those in small communities and those sponsored by cooperatives or nonprofit organizations.

My feeling is that to stimulate interest in the medical profession, naturally the profit motive must always be, and always is, a factor.

I wonder if you feel that this preferential language would be a deterrent to the interest of the private physician. Would you not feel there should be no priority, that it should be available equally to all groups? That would be my feeling.

Dr. JORDAN. I suggested that that part be taken out in this testimony. I do believe that, sir.

Mr. NELSEN. Thank you very much.

I yield back to the gentleman.

The CHAIRMAN. Thank you very much, Doctor.

Dr. JORDAN. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness will be Miss Grace A. Gurisic. Please identify yourself, and then you may proceed.

STATEMENT OF GRACE A. GURISIC, NATIONAL ASSOCIATION OF COUNTIES; ACCOMPANIED BY PAUL CARLIN, ASSISTANT DIRECTOR FOR FEDERAL OWNERSHIP PROBLEMS, NATIONAL ASSOCIATION OF COUNTIES

Miss GURISIC. First, I would like to introduce Paul Carlin, assistant director for Federal ownership problems with the National Association of Counties, who has accompanied me here this morning.

I am an elected freeholder from Somerset County, N.J. During the current year, I am serving as director of the Somerset County Board of Chosen Freeholders. In New Jersey this position is the same as the chairman of the county board of commissioners or supervisors within other States.

I am appearing before your committee today in my dual capacity as an elected freeholder and as an active member of the Mental Health Committee of the National Association of Counties. The National Association of Counties is a nonprofit organization which represents the Nation's 3,043 county governments.

In contrast to the other distinguished witnesses which have appeared before your committee, I would like to point out that I am a lay person as far as mental health is concerned.

I do represent a level of government, the counties, which have the local responsibility for actually raising from the public the required funds to administer and staff the local comprehensive community mental health centers.

County government enthusiastically endorses and supports the fundamental objectives of the local comprehensive community mental health center program, which is to reduce the number of patients in the larger State hospitals to a minimum, and to return these patients to their local communities where they can receive adequate and personal mental health care.

We endorse this new approach to solving the mental health needs of the Nation with the full realization of the financial burden which this concept places upon the local levels of government. The county level of government stands ready and willing to assume its full responsibilities, as a partner with the State and Federal levels of government, to offer increased services in the field of mental health, and to help contribute to the process of restoring twisted and ruined minds back to a useful role as citizens.

County governments' traditional involvement in hospitals, health, and welfare, provide the mechanism for effectively accomplishing these objectives. County governments are indeed their "brothers" keeper.

No one level of government is an island unto itself. What county governments desire is a partnership with the Federal and State governments, particularly during the initial phase of any cooperative program.

This cooperative approach is especially needed to meet the initial costs of new professional and technical personnel which are required for the local comprehensive mental health centers. H.R. 2985 provides a realistic financial approach for such a cooperative effort.

Even though the local levels of government strongly support these objectives, elected local governing officials understandably become apprehensive when they are faced with a new program which shifts additional financial responsibilities to the county tax rolls.

As President Lyndon B. Johnson pointed out last Tuesday in his message on cities the per capita local tax revenues increased by only 43 percent between 1954 and 1963; however, during the same decade, the indebtedness of local government increased by 119 percent.

The President's emphasis on the financial burden of local governments points out that we must have a more realistic approach to the financial crisis which is facing all communities.

As an elected freeholder, I am deeply concerned by the fact that more local officials are defeated on the issue of tax increases than any other single reason. This is true regardless of the merits of any tax-supported program.

With this concern, comes the realistic need to find practical financial solutions to the soaring welfare and human needs of our citizens.

In the field of mental health, the proper staffing of the local comprehensive community mental health centers is a critical factor if this imaginative and beneficial approach is to be a success.

The National Association of Counties strongly supports the objectives embodied in H.R. 2985, since we feel that the Federal Government must take the initial step if this need is to be fulfilled.

This assistance is vitally required during the initial process of developing any new program, since there is a financial lag between the hiring of capable staffs and the actual receipt of revenues.

H.R. 2985 provides the impetus for immediately hiring the mental health specialists who are so vitally needed for these local programs.

The stimulation provided through H.R. 2985 for the initial cost,

however, is not the complete answer to a program which is so vital to the welfare of a forgotten segment of our society.

As the committee is well aware, the financial burden of local governments is soaring out of proportion to their ability to find adequate financing.

If a lasting solution is to be found in the field of mental health, we must be more practical in the permanent financing of local comprehensive community mental health centers.

There must be a positive approach which will provide continued financial assistance to participating local governments.

For this reason, the shift of emphasis from the State mental health hospitals to local facilities should not provide an exit for State governments from the financial role that they now have.

The National Association of Counties urges that the State governments be required to continue to expend on an annual basis an amount of money for their mental health programs which is comparable to their expenditures during each of the preceding 2 years.

The Federal Government should encourage the States to not only provide for the direct costs of their own statewide institutions, but that the States also provide continuing grants-in-aid to their local communities for the continued staffing of local comprehensive community mental health centers.

In summary, the National Association of Counties wholeheartedly supports the objectives of the local comprehensive community mental health center approach to providing new hope for millions of afflicted Americans.

In the process of converting from a 19th-century attitude of neglect to a 20th-century approach of national concern for our mentally disturbed citizens, the county level of government stands ready to assume its full responsibilities and will endeavor to provide the local leadership for encouraging the establishment of local comprehensive community mental health centers, but we need your help.

Passage of H.R. 2985, together with the Federal Government strongly encouraging State governments to continue their financial support to county and municipal governments in the field of mental health so that this vital program's objectives can be fully achieved and so that it can be financially continued, provide the basis for a constructive Federal-State-local government approach to the field of mental health.

I appreciate this opportunity to present these views on behalf of the National Association of Counties.

Thank you.

The CHAIRMAN. Thank you very much, Miss Gurisic, for your statement.

Are there any questions?

Mr. Younger?

Mr. YOUNGER. I think your paper is very interesting, Miss Gurisic. Were you here yesterday when the Governors appeared?

Miss GURISIC. No, I am sorry, I was not.

Mr. YOUNGER. They made the same plea for the State that you make for the counties. They are unable to collect taxes, to provide for their own needs. You propose that the Federal Government force the State to continue the contributions they have made over a 2-year period, on the average, to the counties and cities.

How can the Federal Government force any such action?

Miss GURISIC. Correction, sir, I don't intend to force any level of government. I think we should encourage the State governments.

Mr. YOUNGER. Then what did you mean in the statement you made about the Federal Government—

Miss GURISIC. I believe I stated to encourage the State governments to continue support.

Mr. YOUNGER. Just to encourage?

Miss GURISIC. That is right.

Mr. YOUNGER. I thought the direction was a little stronger than to encourage.

Miss GURISIC. I felt strongly when I said it.

Mr. YOUNGER. I mentioned it to one of the Governors yesterday, because, after all, it is the same taxpayers. You have the same taxpayers, the State has the same taxpayers and so does the Federal Government.

An individual only has one pocket and every level of government has its hands in his pocket. Why do you think people are more willing and happier to pay taxes to the Federal Government than they are to the local government or the State government?

Miss GURISIC. We have, I think, 87.1 percent of the local tax dollar coming from the property tax. This is our only source at our level. We are continually faced with the problem, in my own county which I speak to, where we start with these giveaway programs and then they phase out. Then we have some private funds contributing. They do not make the united fund goal. They continually apply to county government to assist them.

There is no argument. They are vital and important programs. I would like to see a continuation of financial assistance, not something that phases out in just 4 years. If this program is important enough to start in the beginning, then it is very important that we continue it, that it not fail. Otherwise, what is the effect of instituting a program? We need more than just a come-on. This area of mental health is too important that it should fail.

Mr. YOUNGER. The Governors that were here yesterday promised that this would be phased out and they would not be back here asking for money.

Is that not right, Mr. Chairman?

But this does present a real problem. Do you have a sales tax?

Miss GURISIC. In New Jersey we are rather unique. We have neither an income nor a sales tax. I don't think we will ever see a tax until the elected officials are no longer elected. We are unique in New Jersey. But we will be faced with a tax very shortly.

The CHAIRMAN. Is there anything further?

Dr. Carter.

Mr. CARTER. I want to congratulate the young lady on her presentation and her willingness to come out under such adverse circumstances to support this worthy bill, this worthy program.

Miss GURISIC. Thank you, sir.

The CHAIRMAN. Thank you very much. We appreciate having your fine statement and your taking the trouble to come and help us make this record.

Miss GURISIC. Thank you, Mr. Chairman. It has been my pleasure.

The CHAIRMAN. Mr. E. D. Whitten?

Mr. Whitten is the director of the National Rehabilitation Association. He may include his statement in the record at this point.
(The statement to be supplied by Mr. Whitten follows:)

STATEMENT OF E. B. WHITTEN, DIRECTOR, NATIONAL REHABILITATION ASSOCIATION CONSIDERING H.R. 2985, "COMMUNITY MENTAL HEALTH CENTERS ACT AMENDMENTS OF 1954"

I am E. B. Whitten, Director of the National Rehabilitation Association. I am speaking in support of H.R. 2985 entitled "Community Mental Health Centers Act Amendments of 1965". Our concern for this legislation grows out of the fact that the National Rehabilitation Association is doing all it can to encourage voluntary and public rehabilitation agencies to increase their involvement in the rehabilitation of the mentally ill. My personal interest and concern were stimulated through my membership on the Joint Commission on Mental Illness and Health, which conducted a 3-year study of mental illness for the Congress, and upon whose recommendations much recent legislation in the mental health field has been based.

As you will remember, the Joint Commission faced up squarely to the question of Federal involvement in the treatment and care of the mentally ill. Up to that time, the participation of the Federal Government had been limited to research and training of personnel. With rather remarkable unanimity, considering the diverse backgrounds of the individuals who constituted the Commission, the recommendation was that the Federal Government does have a responsibility for treatment, care, and rehabilitation of the mentally ill and that this responsibility included involvement in construction of mental health facilities and in support of the programs of such facilities.

In the first paragraph of this statement, I mentioned the fact that the National Rehabilitation Association has been encouraging expanded activity in the rehabilitation of the mentally ill. We are very much encouraged by some of the activity underway. For instance, in the State of Arkansas, the vocational rehabilitation service, with its own funds and staff, operates a rehabilitation center for the mentally ill on the grounds of the Arkansas State Hospital. The hospital patients who are thought to be ready for this service are transferred to the rehabilitation center, where they live during the concluding months of hospitalization. The hospital continues to furnish maintenance and medical services. In the rehabilitation center, the rehabilitation agency has established a vocational evaluation and certain vocational training programs. This project, once an experiment, is now a tested method of rehabilitating the mentally ill. By the time the patients are ready to be discharged from the hospital, substantial progress has been made in guiding them into suitable vocational objectives and, in many instances, in training them for the work they expect to do. When discharged, the patient goes back to his home community, where the vocational rehabilitation agency continues efforts to finish vocational preparation of the individual and to see that he is placed in suitable employment. Programs similar to this are in operation in Georgia, South Carolina, West Virginia, North Carolina, and a number of other States. In addition, several of the States operate rehabilitation houses for the mentally ill as an interim step between hospitalization and returning to the community. Rehabilitation counselors are frequently assigned to mental hospitals, clinics, etc.

One of the principal weaknesses in these programs grows out of the fact that when the patient returns to community there often is not available to him the type of medical and related services which are necessary during the trying period of adjustment to community living. Rehabilitation agencies recognize the mental health center, to be constructed under the 1963 legislation, to be the answer to this problem. Rehabilitative services are to be provided in the mental health centers. These services are to be coordinated with existing facilities and programs. These mental health centers will certainly be resources to State vocational rehabilitation agencies in their efforts to furnish the rehabilitation programs for the mentally ill, and the vocational rehabilitation agencies will be important resources to the mental health centers. In fact, one may easily visualize an ideal and most effective relationship between the mental health center and the vocational rehabilitation agency.

Personnel of vocational rehabilitation agencies have long recognized the fact that it is impossible for them to work effectively with any mental health program that is not properly staffed to encourage the rehabilitation of the patients. Important as they consider brick and mortar to be, they would quickly point

out that well-trained and dedicated personnel in the mental health centers will be far more important to them than fine buildings in their efforts to rehabilitate the mentally ill. In fact, many of these agencies have had frustrating experiences in attempting to work with State mental hospitals which, although they meant well, simply did not understand the nature of rehabilitation services and did not have the personnel to work effectively with them.

For the Federal Government to help the States and local communities to develop adequate buildings for the treatment and care of the mentally ill is in itself a great step forward. Undoubtedly, a great deal of progress will be made as a result of this legislation. Without Federal assistance for the staffing of the mental health centers, it may be assumed that progress will be continued. States and local communities will do the best they can without Federal assistance. It really becomes a question as to whether we expect to make substantial inroads in the solution of the problems of mental illness in this decade or whether we are willing to wait for the next.

Those experienced in such matters have little doubt but that the availability of Federal funds for staffing mental health centers will stimulate greater activity on the part of the States and the Federal Government, and that progress toward adequate mental health programs will be greatly accelerated. We believe that this country can afford to do what it knows needs to be done in order to deal humanely and responsibly with mental illness.

In our judgment, the issue becomes a simple one. It is not whether H.R. 2985 shall be passed exactly as it is written. It is not whether initial appropriations shall be on an open-end basis or on a limited basis. It is not just how much money the Federal Government is willing to put into such a program during the next few years. It is not the conditions that States and local communities must meet in order to secure the funds. These issues can be easily resolved, once the decision is made with respect to whether the Federal Government has a responsibility to assist States and local communities in providing services directly to mentally ill individuals through contribution to the costs of staff. Although this is a simple issue, it is an important issue. It is one upon which members of this committee may very well be expected to deliberate seriously. In our judgment, such support of State and local community health programs is a Federal responsibility. We see no other way to make the progress we must make in developing these programs.

The CHAIRMAN. The next witness will be Mr. Donald Wilkins, of the Northern Virginia Mental Health Association.

STATEMENT OF DONALD WILKINS, PRESIDENT, NORTHERN VIRGINIA MENTAL HEALTH ASSOCIATION

Mr. WILKINS. Mr. Chairman, members of the committee, I am delighted to follow the representative of the National Association of Counties, because I represent a lay group, the North Virginia Mental Health Association, which are the citizens who are pushing, not the elected freeholders, but the county supervisors in Virginia to assume their responsibility in this.

The Northern Virginia Mental Health Association has within its jurisdiction approximately a half million people. This may or may not include the added starters who are your colleagues, your office staff, or Federal employees who have kept their domiciles at home. They nevertheless have the problems and we have to treat them.

In the northern Virginia area that I represent, which are the counties of Arlington and Fairfax, and the cities of Fairfax and Falls Church, there are over a half million people resident.

Within the last 2 years, by pressure from citizens on the elected officials and by, shall I say, intensive lobbying at the general assembly in Richmond, we have tripled our mental hygiene clinic space in this area, mostly through local bond issues. In other words, the people themselves by referendum have been willing and able to provide us

with the bricks and mortar with which to house facilities to treat our mentally disturbed and mentally ill people. We have a new State mental hospital which is out for bids now, which will be a \$2 million project of approximately 130 beds, to provide intensive treatment locally, which is a project that we started 9 years ago and which we like to think predated the administration's community mental health center facility programs.

We have increased the local government's operating facilities. They now approach approximately a quarter of a million dollars a year for supplemental payment to staff members, professional qualified staff members, in the three mental hygiene clinics which are now operating.

We still have backlogs of anywhere from 2 weeks to 9 months. I did not deliberately choose that 9 months, it just happened to have been that way.

We urge enactment of H.R. 2985 because, despite all the efforts of State and local taxing, of appropriating Government agencies and local agencies, there are not enough qualified professionals, either administrative staff or for treatment, to fill the burgeoning needs of our communities unless seed money is made available to indicate to students and others that there is a reasonable intent on the part of all governments, or even all communities, to assume the responsibilities for the care and treatment of those who can not reasonably speak for themselves, many times because of court order. Within our communities. There never will be enough qualified personnel to keep up with the demand, let alone perform any of the admittedly successful functions in preventing mental disturbances from growing into serious mental illnesses, unless assurance of employment is given.

On behalf of the half million people of whom I guess 50,000 may be subject to benefit under this program, if we take the 10-percent figure that is being used, we urge you to make available to us through our State government the opportunity to adequately staff the bricks and mortar that we ourselves by virtue of Hill-Burton programs and local bond issues are constructing. We need it. I think we all recognize that.

I thank the chairman. I am pleased to have made the statement.

The CHAIRMAN. Thank you very much, Mr. Wilkins.

I notice you had on the agenda here Mr. Watters, president of your board. Is he with you?

Mr. WILKINS. A correction. I am delighted Mr. Watters is here because Mr. Watters is chairman of the advisory committee of the mental health center. He will have a statement which will explain to you how our community mental health center operates and explain the need for this support from the Federal Government in connection with that operation.

The CHAIRMAN. Thank you very much.

Are there questions?

Mr. NELSEN. Mr. Chairman.

The CHAIRMAN. Mr. Nelsen.

Mr. NELSEN. One point I would like to have developed. Almost all of the evidence indicates that these community health centers are a vast improvement over the old system and almost all of the testimony would indicate that great savings are effected because so many people are cured and sent back into society.

Yet it seems the costs are extensively higher in spite of the testimony. Is that because more people are being treated or what is the reason for it? If the States are saving money by transferring to community health centers and discarding the old system, it seems to me they would have available to them the money they used to sell so successfully in the nonproductive program for the community health centers.

Mr. WILKINS. I think probably on the surface it does appear that way. I think there is probably substantial merit to the claim, that the community mental health centers acting in a preventive capacity do remove many from the custodial care of large State institutions. I could be blunter, I guess, if I were in Virginia because I have some personal feelings about such custodial care and what good it does or does not do. It is a little difficult for someone from Virginia complaining too much about costs because we are 45th on the totem pole.

It is a little difficult for us to answer this inquiry because, frankly, unlike Michigan, New York, Illinois, as I heard yesterday as testified by the Governors, we have about as much on a 2-year biennium for maintenance of our State hospitals as they have for a year.

We operate all of our clinics in the Commonwealth of Virginia from State appropriations of approximately a quarter of a million dollars on a 2-year period against Governor Volpe's \$800,000 per year for administrative personnel.

In other words, I am not sure I would be qualified to answer, I can say, with respect to Virginia, assuming that there is a cost of \$4 and roughly 70 cents a day per patient in the State mental hospitals, the average length of stay of any committed person, and this is primarily because of staff shortage and the inability to do the analysis and suggest treatment, therapeutic treatment, the average stay is approximately 6 months. This means that every person committed to the State hospital has a guaranteed cost of almost \$900. This is an operating cost. If that person is not committed and is treated locally through day care centers or through local community mental health centers it seems elementary to me that the saving will unquestionably result in increased use and support by the State of mental health centers.

I think I might question the National Association of Counties, suggestion because I believe that, as that money is made available by reducing operating cost of the State hospital, the general assemblies under their new reapportionment representing the areas that they come from, that those savings will be channeled into picking up the cost of the qualified executive personnel for the community mental health centers.

At least I can assure that there will be at least 17 general assembly delegates from northern Virginia who will ask for that, probably fight for it. This I think is the problem of marshaling of community strength to demand this.

I know it is pretty difficult to talk to elected representatives and suggest that citizens demand something. But you have wastepaper baskets full of demands so you know what I am talking about.

Mr. NELSEN. Thank you very much.

No more questions.

The CHAIRMAN. Anything further?

Mr. CARTER. Is this not really a bigger problem than many people realize?

Mr. WILKINS. Mr. Carter, I got into this 10 years ago as a volunteer because I couldn't say no. The answer bluntly is yes. Nobody realizes it.

Mr. CARTER. Would it not be a revelation for some of us to visit some of the mental hospitals throughout the country?

Mr. WILKINS. I think that all of you would be shocked, chagrined, dismayed, and bluntly, mad if you did have occasion sometime to visit the hospitals other than when a legislative delegation is being shown through the hospitals. You see only the best at that time.

The CHAIRMAN. Can you give us assurance that we will get out?

Mr. WILKINS. Mr. Chairman, I had a wife who was a county supervisor for 12 years. I have argued for 13 years that she didn't have as much sense as those who do the electing or she wouldn't have run for office in the first place.

The CHAIRMAN. Mr. Wilkins, thank you very much. We appreciate your testimony this afternoon.

Mr. WILKINS. Thank you.

The CHAIRMAN. We will take Mr. Frank Watters now, president of the lay advisory board.

Mr. Watters?

STATEMENT OF FRANK WATTERS, PRESIDENT, LAY ADVISORY BOARD, FAIRFAX-FALLS CHURCH MENTAL HEALTH CENTER, FALLS CHURCH VA.

Mr. WATTERS. Mr. Chairman and members of the committee, I am Frank Watters, president of the board of directors for the Fairfax-Falls Church Mental Health Center which serves residents living in Fairfax County—a 412-square-mile land area—and the city of Falls Church. As you, I am sure are aware, Fairfax County is one of the fastest growing residential areas—not only in the Nation's Capital region but also in the United States.

May I thank you for the opportunity to appear before your committee to testify in support of H.R. 2985, a bill to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers.

I am also identified with health care in other capacities—currently, as a member of the board of the Northern Virginia Mental Health Association and as a past president of that organization. I am also executive director of Group Health Association, Inc.—a comprehensive medical care plan serving Washington area residents and known as GHA, and we have a large medical center at 2121 Pennsylvania Avenue.

Though our GHA members are for the most part Federal employees we also serve the employees of the D.C. Transit System and other groups—and of course these people live throughout the metropolitan area.

However, I am here today because of my relationship to the mental health center—located at Seven Corners in Fairfax County—near Falls Church, Va. This is an active medical facility with a professional staff of psychiatrists, psychologists, social workers, and supporting personnel. There were some 13,000 patient visits last

year—and the workload is in the neighborhood of 250 patient visits a week. This, of course, varies. I am just giving you a level figure.

Our medical director is Dr. Simon Auster, a psychiatrist who has had special training in child psychiatry.

As I was sitting here listening to the preceding witnesses I decided to call him and ask him if he would like to join me. He said he had a family coming in at 1 o'clock and another family at 2 and another family at 3 o'clock. He said, "Unless it is very urgent, Mr. Watters, I don't believe I ought to take time to do it."

In excusing him it crossed by mind how much more difficult it is to treat this type of patient—the time it takes, I mean. He is going to see three patients—one an hour. A pediatrician can see, I am sure, two or three or four children an hour. An internist maybe a somewhat lesser number. Certainly in OB-GYN, three or four patients an hour can be seen. When you are dealing with mental illness you are dealing with something that requires a professional's time to much greater degree than any other speciality possibly, except for surgery.

The Fairfax-Falls Church Mental Health Center, I believe would be an eligible agency under section 221(a) of the bill as it is supported by public funds and is a nonprofit community mental health agency. Though in some instances fees are charged for treatment, such income represents only some 15 percent of our annual budget, which is financed by Federal, State, and local tax funds. Last year our budget was \$180,000. For the year starting July 1, 1965, we are asking the public authorities for some \$225,000.

The Fairfax-Falls Church Mental Health Center is the only public clinic serving a population of some 375,000 persons. The center originated many years ago as a child guidance clinic to assist parents with emotionally disturbed children.

I should say, that at that time it was financed, largely, by United Givers Fund money.

The emphasis today is much broader and includes children and adults. The center is evolving into one of the important community mental health centers in the Washington area.

Our center works closely with the school systems, the welfare departments, and the courts.

I might add here that our school system in Fairfax County has between 90,000 and 100,000 children.

The potential caseload is far greater than we are able to properly serve. The National Institutes of Mental Health—I am told by our medical director—has estimated that for our population base the center is about one-third the size it should be—staffwise. Also there are several worthwhile facets lacking in our program.

Approximately 20 percent of the center's children's caseload is referred by the schools because of learning difficulties. This is usually because the school psychological service has determined that the problem goes beyond the capacity of the school system for treatment. In other words, that the child is in need of some professional expertise that the normal school staff is not able to provide.

Because of staff limitations we are completely unable to attempt a specific evaluation for the school authorities of learning difficulties of particular children, beyond a general psychological evaluation—except in rare instances.

Even where we provide services, there is generally some delay. The average wait for a first interview for a family referred to the clinic is 1 month. The average time period for evaluation is from 3 to 4 months. Emergency cases can usually be seen within a day or two but—if it is anything short of murder or a threatened suicide—2 weeks is a more reasonable period of time before seeing emergencies. The seasonal nature of children's referrals makes the problem even worse. Referrals are light in the summer but begin picking up in the fall and come to a peak between January and April.

Unfortunately, with the limited staff, during the peak months, this delay in treatment can often stretch into 5 or 6 months—to the detriment of the child involved. We are caught in the somewhat bizarre situation of being a community agency that desires to offer services to the community—while being at the same time one that tries as much as possible to avoid publicity—as this is likely to result in even more referrals, which are quite appropriate, but which we are completely unable to handle.

I might make a digression here. Professionals, as I am sure you understand, when they are loaded with a backlog of patients sometimes get discouraged and become unhappy with their work situation. We want to keep our staff—at least the staff we have.

For a community of our size—population and areawise—the best estimates I can obtain is that our staff should be tripled in size. We have 21 professionals—psychiatrists, psychologists, social workers, and specially trained professionals—or 10 “full-time equivalents,” because some of the professionals—psychiatrists and sociologists—are on a part-time basis.

The critical program areas which should be undertaken are day-care programs for children and adults—under both the preventative and rehabilitative headings.

There are no “day-care” programs available in the county either for adults or for children. Approximately 15 patients per month are committed to Western State Mental Hospital at Staunton, Va., from Fairfax. Carefully controlled studies—according to our medical director—show that at least 60 to 75 percent of these people could be maintained in the community if day care were available. This would be not only more humane, but also it would be economical. The average duration of stay for a first admission to a State mental hospital is about 6 months.

The average length of treatment is less than 2 months in a day care center in the community—if intensive. Not only would the therapeutic benefit of day care be immeasurably superior but the overall cost per patient for day care near home would be less drain on overall tax dollars.

Don Wilkins, president of the Northern Virginia Mental Health Association, gave you a figure of \$4.07 as being the per-diem cost for Virginia mental hospitals. As he also testified, it is largely custodial care. It is not intensive treatment. They do discharge patients on drugs in about 6 months, send them home and then back they go again to the hospital. At \$4.07 a day, 180 days or 6 months, the total, is under \$900. Day care per-diem cost might run as high as \$15. My medical director tells me if you can get them

out in 40 to 60 days you are making a saving in each case of about \$300 in spite of the higher per-diem cost. If we have 15 patients a month going down to Staunton, Va., from Fairfax County and 75 percent could be treated at home—5 would go, 10 would stay at home—we could develop some figures which would show you what the dollar savings would be in day care at home versus the State mental hospital.

In the area of day care for children there is also considerable inadequacy. During the course of the past year the center treated many children under the age of 6. Of these, a day care program would have been the treatment of choice for many of them if such a program had existed. In its absence stopgap measures have been used—maintaining the child on outpatient treatment once or twice weekly—because the alternative—hospitalization in a large mental institution was too unpleasant even to consider. We should have no illusions that what we are presently offering to Fairfax County and Falls Church residents even remotely approaches a desirable program.

Your hearing record, I would assume, has much in it regarding the extent of mental illness and the need for more and better treatment facilities in our country. To give you a grass roots picture, so to speak, has been my purpose in testifying here today. In concluding, I would like to add that assistance to local communities—as provided under H.R. 2985, section 220—would be a step forward in meeting what is one of the most critical health problems we have today. If our Federal Government provides the support necessary to permit the local community leadership to initiate adequate programs, I believe that local acceptance and financing will be more readily obtained.

Any member of the committee or its staff—who might wish to visit the center—is very welcome to do so. Should the committee desire any case documentation or support statistics, I will be glad to try and furnish them for the record.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Watters.

Are there any questions?

We appreciate your statement and we are glad to have this information from your experience. We hope that we might have an opportunity to visit your facilities.

Mr. WATTERS. They are not very far. They are out at Seven Corners. If you wish to come, give us a call and we will be glad to take the committee out in toto, if they would like.

The Chairman. Thank you very much for your generous invitation.

Mr. WATTERS. We will let you come back, too.

The CHAIRMAN. We appreciate the assurance.

At this point, for the record, I have a wire from Dr. Alvin R. Yapalater, who is the secretary of the Council of the New York State District Branches of the American Psychiatric Association in support of 2985.

Likewise, we have a wire from the Arkansas Chapter of the National Association of Social Workers, Mr. Dean Rogers, the social action chairman from Little Rock, Ark., all supporting H.R. 2985.

We are in receipt of a wire from Mr. William P. Hurder, associate director of Mental Health Training and Research, Social Regional Education Board, Atlanta, Ga.

We have a communication referred to us by our colleague, the Honorable John B. Lindsay, with reference to H.R. 2987. It is from Mr. James Brindle, president of the Health Insurance Plan of Greater New York.

These communications will be included in the record. I have also a wire from Mr. George G. Budney, president of the California Association for Mental Health in the interest of 2985 which will be included in the record.

(The documents referred to follow.)

WHITE PLAINS, N.Y., March 3, 1965.

HON. OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.:

The Council of the New York State District Branches of the American Psychiatric Association, representing approximately 2,000 psychiatrists in New York State, is strongly in favor of H.R. 2985 which would provide appropriations for stamping community mental health centers.

ALVIN R. YAPALATER, M.D.,
Secretary, Council of New York State District Branches.

LITTLE ROCK, ARK., March 4, 1965.

HON. OREN HARRIS,
House Office Building,
Washington, D.C.:

We urge your support of H.R. 2985. Provisions for staff is essential if mental health facilities are to become a reality.

ARKANSAS CHAPTER OF NATIONAL ASSOCIATION
OF SOCIAL WORKERS,
DEAN ROGERS, *Social Action Chairman.*

ATLANTA, GA., March 4, 1965.

HON. OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee, House Office Building,
Washington, D.C.

DEAR SIR: Strongly urge your committee review experience of Texas in pooling State and private resources to provide community care for mentally ill, as background for H.R. 2985. Texas program developed and directed by Dr. C. J. Ruilmann, director, Board for Texas State Hospitals and Special Schools, Austin, Tex., who is best qualified to describe. Sincerely believe program demonstrates, in way which may help your committee's deliberations, both feasibility and desirability of blending public and private resource.

Respectfully,

WM. P. HURDER, M.D.,
Associate Director for Mental Health Training and Research, Southern
Regional Education Board.

SACRAMENTO, CALIF., March 1, 1965.

HON. J. ARTHUR YOUNGER,
House of Representatives, House Office Building, Washington, D.C.:

The California Association for Mental Health considers favorable action on H.R. 2985 of the greatest importance in an all-out attack on mental illness. Funds to help staff services for the mentally ill are of equal importance to the construction assistance provided by last year's Congress. Your support of H.R. 2985 will be greatly welcomed by all Californians working aggressively in behalf of the mentally ill.

Sincerely,

GEORGE G. BRUDNEY,
President, California Association for Mental Health.

HEALTH INSURANCE PLAN OF GREATER NEW YORK,
New York, N.Y., February 23, 1965.

Hon. JOHN V. LINDSAY,
House of Representatives, Washington, D.C.

DEAR MR. LINDSAY: The Health Insurance Plan of Greater New York, with 31 affiliated medical groups providing medical care to more than 700,000 persons, urges your support of H.R. 2987 for group practice facilities. The mortgage insurance and loans provided for are needed in many parts of the United States and will be helpful in New York.

Sincerely yours,

JAMES BRINDLE, *President.*

The CHAIRMAN. Have we overlooked anyone?

This concludes the hearings on these four bills, legislative proposals. The record will remain open for 5 days for anyone who desires to submit statements appropriate to this record.

With my thanks to the members of the committee for your attention and cooperation and your assistance in helping us to develop a good record and with my thanks to all of those who have appeared in the interest of and testifying with reference to these four important proposals, the committee will now adjourn.

(The following material was submitted for inclusion in the record:)

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., March 2, 1965.

Hon. OREN HARRIS,
*Chairman, Interstate and Foreign Commerce Committee,
U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN HARRIS: We are pleased to note that you have introduced H.R. 2984 in the House of Representatives of the United States to amend the Public Health Service Act, providing for construction of health research facilities by extending the expiration date thereof and providing increased support for the program to authorize additional assistant secretaries in the Department of Health, Education, and Welfare, and for other purposes.

As we interpret the provisions of this bill, it would do the following:

1. Extend the health research facilities construction grants program for another 5 years but at an increased level of spending to provide research facilities and for related purposes. Grants may not exceed 50 percent of the construction cost.

This program has been very effective over the past years in promoting research in general and research potentialities of many hospitals in particular. We are heartily in favor of this extension.

2. H.R. 2984 would add a new section, 712, to the Public Health Service Act authorizing the Surgeon General to construct and, if necessary, pay up to 100 percent of the construction cost of "facilities of particular value or significance for the Nation or region thereof." As we understand it, this section restores a provision previously in the Public Health Service Act but which, for some reason, was later removed. We feel that this provision would make possible the construction of certain specialized research facilities of value to the Nation as a whole but which because of their specialized nature could not be even partially financed with private funds. For the same reasons, such centers might be impossible to operate even in part with local funds; and the authorization for the Surgeon General to operate such research facilities is a logical corollary provision. We feel that these provisions constitute desirable additions to the Nation's research programs.

3. Section 3 of H.R. 2984 amends section 301 of the Public Health Service Act to authorize the Surgeon General, with the approval of the Secretary of the Department of Health, Education, and Welfare, to enter into contracts for research in accordance with and subject to the provisions of law applicable to contracts entered into by the military departments under title 10, United States Code, sections 2253 and 2254.

We understand that this amendment provides a firm statutory base for a program which has heretofore been authorized from year to year in appropriation language and thereby subject to point of order. We feel that this is a desirable provision in that it would remove much of the uncertainty from an ongoing and valuable means of conducting research.

4. Section 4 would provide for three additional assistant secretaries of the Department of Health, Education, and Welfare. It would also abolish the position of special assistant to the Secretary (Health and Medical Affairs) and provide that the incumbent immediately prior to the enactment of this legislation may act as one of the three additional assistant secretaries until the office can be filled by appointments in the manner provided by this section.

We question only the vagueness of this section as it relates to health and medical affairs. We feel it imperative that one of the three assistant secretaries be competent in and responsible for health and medical affairs in the Department.

We appreciate the opportunity of expressing our views on this bill and request that they be made a part of the record.

Sincerely yours,

KENNETH WILLIAMSON,
Associate Director.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., March 2, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN HARRIS: This statement is sent to you to express the views of the American Hospital Association in respect to H.R. 2985, a bill to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers.

The American Hospital Association fully supported the legislation which resulted in the Community Mental Health Centers Act. At the time the legislation was being considered, we reviewed the history of the developing role of the acute, short-term general hospitals of the Nation in the treatment of mental illness. We expressed our belief that the general hospital was the most appropriate place in which the purposes of the act could be carried out. We reiterate our strong belief that it is essential that the treatment of the mentally ill be provided to the fullest extent possible within the "main stream" of medical practice. The most direct means of accomplishing this end is through the placement of community mental health centers wherever possible in general hospitals.

Since the passage of the Community Mental Health Centers Act, our association has devoted extensive efforts to acquainting the general hospitals of the Nation with the act and with its intended purpose. We have in various ways encouraged hospitals to participate fully in the development of statewide studies and in the appointment of commissions to advise and influence the development of the program within the States. We have also urged hospitals to extend their services wherever necessary so as to encompass the purposes of the act. We have greatly appreciated the fine cooperation of the Federal authorities responsible for the administration of the program. We have had several conferences with these authorities and found them most cooperative and understanding of the problems involved. We believe the groundwork has been well laid, and the program is being undertaken in a satisfactory manner.

The Community Mental Health Centers Act does not provide for Federal financial assistance in the staffing and operation of the centers. H.R. 2985 proposes to provide such assistance. It would authorize the Secretary to make grants to community mental health centers for compensation of professional and technical personnel not to exceed 75 percent of such costs for the first 15 months of operation, 60 percent of such costs for the first year thereafter, 45 percent of such costs for the second year thereafter, and 30 percent of such costs for the final year of the program as authorized.

We have studied carefully the pros and cons of this proposal. It is recognized that the availability of such direct Federal subsidy may well encourage the development of the community mental health centers at a more rapid pace. However, we are deeply concerned with the far-reaching implications of such a proposal. We do not foresee that the mental health program envisioned under the act will terminate at the end of its presently authorized 5-year period. In fact, we believe the program will only be well started; and the centers will only then be well developed so that the program will be geared for its full potential to follow. Also, the need for financing such centers will not end with the termination of the 5-year period established under the act.

It is our belief that the Congress should at this time establish a framework for the program which recognizes the long tradition of the responsibility of State government in the care of mental illness. As more and more of the care of the mentally ill is provided in public and private nonprofit facilities outside of State mental institutions, it is well, we believe, to establish governmental assistance in such a fashion that it will not relieve the States of their financial responsibility. We believe, therefore, that this bill should require continuing State participation in the financing of the community mental health centers. The grants to be provided under H.R. 2985 should, therefore, be established on a matching basis.

The bill at present does not reflect the effect of the Federal subsidy upon charges to be made to patients for the services rendered in community mental health centers. We believe that the subsidy provided by the bill should result in lower charges for those unable to pay the full costs of care and should not result in subsidy to those individuals who are able to pay the full costs of care.

The voluntary health insurance field is making rapid strides to include protection against the costs of mental illness as a part of their programs of benefits. These efforts should provide increasingly for financing of the costs of care in community mental health centers. Care should be taken to insure that Federal money does not supplant or replace these means of voluntary financing.

In our opinion, it is literally impossible at this time to foresee the costs of the personnel necessary to the functioning of the community mental health centers and to estimate in any reasonable manner the full extent of the obligation which the Federal Government may be assuming. It is for these reasons that we would urge that the Federal Government encourage the development of the community mental health center program in such a way as to encourage and even require funds from all possible sources in addition to those which may be provided by the Federal Government.

We again wish to express our support of the mental health program. We appreciate the opportunity of providing you with the views of the American Hospital Association on what we believe to be a most significant bill. We would appreciate your making this letter a part of the record of hearings on H.R. 2985.

Sincerely yours,

KENNETH WILLIAMSON,
Associate Director, American Hospital Association.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., March 2, 1965.

Hon. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.*

DEAR CONGRESSMAN HARRIS: This letter is written to you in respect to H.R. 2986, a bill to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health and for other purposes.

The American Hospital Association supported the Community Health Services Act when it was originally introduced. We wish at this time to express our sup-

port of the proposed amendments which will extend the act for a further period of time and expand its purposes.

We are particularly pleased that the representatives of the Department of Health, Education, and Welfare in their testimony have interpreted the provisions of the bill in respect to health services to migratory workers so as to permit the payment for hospital care. This interpretation is further supported in the report of the Senate committee which considered the bill.

This association has conducted studies in respect to the provision of health services to migratory workers and has consulted extensively with the authorities in the U.S. Public Health Service who are particularly informed on the subject of the health of migratory workers. We believe the interpretation allowing for the payment of hospital services is needed.

This need is supported by information provided us from a number of hospitals in migratory labor areas. The provision should assist materially in defraying financial burdens which now must largely be absorbed by hospitals. Also, and most importantly, it should serve to encourage the extension of needed hospital care to migratory workers and their families.

We congratulate you and your committee in your efforts to further consider the health needs of this segment of the American population. We appreciate this opportunity of expressing the views of this association, and we request that this letter be included in the record of your hearings.

Sincerely yours,

KENNETH WILLIAMSON,
Associate Director, American Hospital Association.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., March 2, 1965.

HON. OREN HARRIS,
*Chairman, Interstate and Foreign Commerce Committee,
U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN HARRIS: This statement is sent to you to express the views of the American Hospital Association in respect to H.R. 2987, a bill to authorize mortgage insurance and loans to help finance the costs of constructing and equipping facilities for the group practice of medicine or dentistry.

We wish to make clear that this association has no position of opposition to the group practice of medicine or dentistry. We do have concerns, however, with respect to certain of the proposals embodied in H.R. 2987.

The bill provides for the Federal Government to participate in financing the construction of group practice facilities operated as proprietary endeavors. The bill also appears to establish an interest rate which is less than that generally available through commercial channels. This constitutes governmental assistance and subsidy to proprietary enterprises. We know of no justification for the Federal Government to establish such a program for the construction of what are essentially physicians' offices. There is presently available a program through the Small Business Administration which provides loans on a short-term basis and at regular commercial interest rates. This loan program is available for construction of proprietary group practice facilities, for physicians' offices and other proprietary health facilities.

Assistance by the Federal Government limited to nonprofit group health facilities may well have merit. However, particular care should be taken that the Federal Government does not assist in the financing of major diagnostic facilities in connection with such group practice endeavors which duplicate facilities already existing in community hospitals. Many of these community hospital facilities have been constructed with the assistance of Federal Government funds through the Hill-Harris program. This is of particular concern also in respect to shortages of health personnel needed for the operation of such diagnostic facilities. Any

unnecessary duplication of facilities, therefore, may further aggravate the shortage of health personnel.

We would appreciate your making this letter a part of the record of the hearings on this bill.

Sincerely yours,

KENNETH WILLIAMSON,
Associate Director, American Hospital Association.

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, INC.,
Ann Arbor, Mich., February 26, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: My colleagues and I wish to endorse strongly two bills currently before your committee—H.R. 2984 (as S. 512 title) and H.R. 2986 (title as S. 510). Both of these bills, in our opinion, are important to health progress in this country.

While our major interest is in H.R. 2986, we are very much concerned with the need for expansion in health research facilities. At the present time, all of our schools are being forced to turn down excellent and promising research projects because of inadequate space in which to work. The provisions in H.R. 2984 and the new flexibility provided are, in our judgment, exceedingly important steps.

The very success of the several programs that H.R. 2986 seeks to extend are the most important arguments for passage of this legislation. For example, experience in this country and abroad underline the importance for every community to maintain a high level of immunization against infectious diseases. Recent great developments in agriculture production have highlighted the importance of migrant labor and as the use of migrant labor grows, health problems become more prominent. Formula grants to State health departments are a potent means for improving the services of these agencies to the general public.

Our particular concern, of course, has to do with the continuation of the authority under section 314(c)(2) to provide formula grants to schools of public health. On previous occasions I have had the opportunity to testify before your committee in order to supply specific illustrations of the great value of these grants in helping to meet the exceedingly high cost of education of professional personnel and public health. As you are well aware, the 12 schools of public health in the country¹ are the Nation's sole resource for comprehensive training of professional public health personnel. In discharging this task, these schools face the problem that university and State legislative funds are not easily obtained when, as in the case of my own school, more than 75 percent of our students are out of State. As a matter of fact, during the current year our student body comes from 41 different States of the Union and 26 foreign countries.

A strong recommendation for continuation of the formula grant authorization to schools of public health was made by the Second National Conference on Public Health Training, held in August 1963, at the direction of the Congress. The conference further recommended that the authorization be increased steadily to a total of \$5 million. While the conference's recommendation called for step-wise increments, my colleagues and I now ask that the authorization in H.R. 2986 be increased from \$2.5 to \$5 million. Our justification for the immediate increase has to do with two important developments. One, since the conference was held, two universities have developed specific plans for schools of public health to the extent that it seems quite certain these schools will be accredited by

¹ University of California (Berkeley); University of California (Los Angeles); Columbia University; Harvard University; Johns Hopkins University; University of Michigan; University of Minnesota; University of North Carolina; University of Pittsburgh; University of Puerto Rico; Tulane University; Yale University.

the time this legislation becomes operative. Since section 314(c)(2) provides for division of the funds appropriated among all accredited schools of public health, failure to increase the authorization at this time would result in an actual decrease of appropriation as soon as the new schools are accredited.

A further argument has to do with the recent increase under Public Law 88-497 of authorization for traineeship grants for students to attend schools of public health. These grants, which for the current year total \$4.5 million, will, in fiscal year 1966, go to \$7 million, then subsequently to \$8 and \$10 million. This large increase in traineeships will inevitably throw a much greater load of students on our schools. The teaching facilities at present are strained to the utmost and it, therefore, becomes essential that additional support for faculty and teaching materials be found.

For these reasons we respectfully urge that H.R. 2984 and H.R. 2986 receive the approval of your committee and, in the case of H.R. 2986, that the authorization under section 314(c)(2) be increased from the \$2.5 million presently provided in the bill to \$5 million. I should emphasize that an increase in this subceiling will not necessitate any increase in the overall ceiling for section 314(c), as recent appropriations have indicated there is ample room for the proposed change.

Very sincerely yours,

MYRON E. WEGMAN, M.D.,
President, Dean, School of Public Health,
the University of Michigan.

UNIVERSITY OF CALIFORNIA, BERKELEY,
SCHOOL OF PUBLIC HEALTH,
Berkeley, Calif., March 1, 1965.

HON. OREN HARRIS,
Chairman, House Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: Last weekend when I was in Washington I learned that you soon will hold hearings on your two bills, H.R. 2984 and H.R. 2986. I immediately wrote to our three California Congressmen on your committee, John Moss, Lionel Van Deerlin, and J. Arthur Younger, copies of which I have enclosed.

When these two bills were heard as S. 512 and S. 510 before the Senate Subcommittee on Health, I was privileged to present a written statement in behalf of S. 512 and oral statements for both bills. I shall not repeat those rather extensive remarks; however, both are crucial to the health of our people, as your introduction of them clearly documents.

H.R. 2984, to continue health facilities research construction, is of greatest importance if we are to provide facilities for our research abilities.

H.R. 2986 provides indispensable resources for continuing sustained control of polio, diphtheria, whooping cough, tetanus. Moreover, it will enable us to apply our new knowledge of vaccination against measles and move forward against any epidemic diseases for which applicable vaccines are discovered.

The project grants for health services for migratory workers partially meet our national responsibilities to these roving pockets of poverty. While States like California meet their share, the problem is truly national. The previous authorizations enabled us to begin development of these services, but now great augmentation is essential.

The continuation of section 314(c) is essential for all State and community health programs, also provided in H.R. 2986. We do urge consideration of increasing the authorization subceiling of section 314(c)(2) from \$2.5 million to \$5 million in line with the recommendation of the Second National Conference on Public Health Training to meet the expanding requirements of our national schools of public health. This increased authorization for the subceiling would not disturb the overall ceiling for section 314(c).

In closing, Chairman Harris, may I express a deep gratification that you are willing to take on the additional burdens of serving as the chairman of the Subcommittee on Public Health and Safety. All of us who had the privilege of hearing you address the American Public Health Association and honor the APHA in receiving its Presidential Citation take the greatest satisfaction in seeing this further evidence of your distinguished statesmanship in the cause of public health.

With cordial best wishes,

Sincerely yours,

CHARLES E. SMITH, M.D., Dean.

NATIONAL ASSOCIATION FOR RETARDED CHILDREN,
New York, N.Y., March 1, 1965.

Re support for H.R. 2984, H.R. 2985, and H.R. 2986.

Hon. OREN HARRIS,
U.S. House of Representatives, Washington, D.C.

DEAR MR. HARRIS: The National Association for Retarded Children wishes to express its support for each of the three cited bills in the health field recently introduced by you and now before your Committee on Interstate and Foreign Commerce.

Although the benefits to be expected for the mentally retarded are, for the most part, incidental to the main objective of the bills, we see in each some potential contribution to the prevention, care, or treatment of the condition which is our major concern. Thus each will advance in some measure the achievement of the total program to which your efforts have already contributed so significantly.

We are enclosing a brief statement on each of these bills, and will, of course, be glad to elaborate on any of them should your committee so desire.

Sincerely yours,

Mrs. FITZHUGH W. BOGGS,
Chairman, Committee on Governmental Affairs.

Enclosures.

STATEMENT IN SUPPORT OF H.R. 2984 (HEALTH RESEARCH FACILITIES AMENDMENTS
 OF 1965)

1. As an organization vitally interested in the promotion of health-related research in a wide range of scientific fields, National Association for Retarded Children, Inc. is cognizant of the benefits which are beginning to accrue from the Health Research Facilities Act, and therefore endorses its extension beyond fiscal year 1966, with increased statutory authority for appropriations.

2. We also commend the proposed addition of a section providing for construction and operation of specialized regional or national research facilities on a contract basis without specification of limit on the Federal share of the costs of same. We foresee advantages in placing certain specialized facilities in locations peculiarly suited to their mission, or in sections of the country where such a nucleus facility would serve to create a community of highly qualified scientists and in addition could be expected to attract other associated research enterprises, resulting in general advantage to the region and (through the better distribution of scientific manpower) in more rapid achievement of national goals in the health sciences.

3. The proposal to clarify the authority of the Surgeon General to enter into contracts for research with both nonprofit and profitmaking corporations can advance the national interest. The contract mechanism has proved very useful in the defense field in directing the resources of private agencies and corporations to the solution of specific scientific problems which are a needed part of a larger public enterprise. We are especially interested in seeing it made possible for the Surgeon General to contract for studies which are needed but which are not of a type for which spontaneous grant applications are likely to be made. We in the National Association for Retarded Children have encountered problems which will yield only to such an approach. For example, from time to time claim is made of the efficacy of some alleged treatment for mental retardation. Presently available funding mechanisms do not induce scientists to make the necessary independent verifications of such claims, yet the public is likely to be misled in the absence of definite independent verification or negation.

4. NARC recognizes a need to strengthen the Office of the Secretary of Health, Education, and Welfare because: (1) the total volume of activity in the Department of Health, Education, and Welfare has increased markedly in recent years, (2) the points of contact with other departments and independent agencies are increasing, and (3) the need for coordinating the activities of the various constituent agencies within Health, Education, and Welfare is becoming especially urgent in relation to programs, such as those in mental retardation which by their nature cut across the assigned missions of the respective agencies. Therefore the authorization for three additional Assistant Secretaries seems to us justified at this time.

STATEMENT IN SUPPORT OF H.R. 2985 (COMMUNITY MENTAL HEALTH CENTERS ACT AMENDMENTS OF 1965)

The National Association for Retarded Children supports H.R. 2985 as introduced. We particularly commend the inclusion of assistance in financing new types of service to be provided in mental health center complexes, without reference to the source of funds for housing such programs.

NARC has long believed that all elements of a comprehensive program for the mentally retarded cannot be provided by any one agency alone and that therefore each of a community's major health, education, welfare, rehabilitation and mental health agencies must contribute its appropriate part of such a comprehensive program for the retarded. The newly developing community mental health centers clearly have such a part to play and one or more services to contribute to the well-being of the retarded.

Many of the mental health centers which will be established under the impetus of the Community Mental Health Centers Construction Act of 1963, and H.R. 2985, will, for the time being, be limited, of necessity, to the five "essential elements" specified by the Secretary. Even these minimal mental health centers should be prepared to render:

(1) outpatient and inpatient psychiatric treatment to the retarded with serious emotional disturbances as well as those with acute psychotic episodes

(2) psychiatric consultation service to other community agencies rendering major service to the retarded, such as schools, child welfare services, rehabilitation and recreation agencies, and local residential facilities.

So that they may perform these functions effectively we trust that all centers will be encouraged to develop an orientation toward the retarded on the part of their professional staff which has not been generally apparent in mental health clinics and centers heretofore.

With respect to diagnosis, it is recognized that children and adults with developmental disorders, whose manifestations may include cerebral palsy, convulsive disorders, language disorders, sensory loss, and specific learning disabilities as well as mental retardation, require a range of evaluation and rehabilitation services including the psychiatric yet going beyond those which can be provided by the mental health professions. We foresee that where community mental health centers are developed within the context of university or general medical centers, they can enrich, and be enriched by, the capacity of the latter to provide sound diagnostic and evaluation services to the retarded and other handicapped persons.

We also believe that the encouragement offered by H.R. 2985 to mental health centers to develop new types of service within the center complex will make possible some creative approaches in the more versatile mental health services. They will thus have an opportunity to demonstrate the extent to which it is practical to incorporate certain additional specific services to the retarded in the mental health centers.

STATEMENT IN SUPPORT OF H.R. 2986 (COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965)

National Association for Retarded Children, Inc., supports and recommends early passage of H.R. 2986. Our reasons are twofold:

(1) As an organization interested in prevention of mental retardation arising from any cause, we welcome the Federal assistance which H.R. 2986 will provide to extend programs of immunization to measles. Although the public is not generally aware of the fact, measles encephalitis in children is one of the many causes of severe mental retardation.

We also commend the general authorization included in the bill to the Surgeon General to follow up promptly on scientific discoveries, which may confidently be expected in the future, relating to other infectious diseases. Several such diseases are already known to be active in causing mental retardation in utero and more will probably be discovered as a result of the collaborative perinatal study now under way under the sponsorship of the National Institute of Neurological Diseases and Blindness. As soon as safe methods of immunization may be developed for any one of these, no time should be lost in putting the new knowledge to use to protect the public.

(2) Section 314 and 316 of the Public Health Service Act have proven to be very useful in the prevention and control of a number of public health problems; we anticipate even greater future usefulness in the field of chronic disability associated with mental retardation. We recognize the need for review of the sections, which will shortly expire, and believe it very wise to extend both now through fiscal 1967 so that there may be no loss of continuity resulting from the congressional study of revisionary legislation which will be proposed a year hence, after the review by the Department of Health, Education, and Welfare and by the State and territorial health officers and others.

NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.

Washington, D.C., March 1, 1965.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN HARRIS: The National Association of Social Workers welcomes this opportunity to register its support for H.R. 2985 which authorizes grants to meet a portion of the cost of compensation of professional and technical personnel for the initial operation of community mental health centers. We understand that the hearings are now being conducted on this legislation.

Our membership, composed of 45,000 social workers who are engaged in a wide range of governmental and voluntary health and welfare services including mental health programs, supported strongly the Mental Retardation and Community Mental Health Facilities Community Construction Act of 1963, Public Law 88-164, that you introduced and engineered to success in 1963.

We were disappointed that the administration's recommendations in 1963 that funds for staffing these mental health centers were not included in the legislation.

We have been impressed with the high level of planning that has been invested in programs of comprehensive mental health centers and the progress that has been made in this program during 1964 despite the lack of Federal support for essential professional services. As you know the report of the congressionally authorized Commission on Mental Health and Illness outlined the basic necessity for comprehensive mental health centers and the importance of funds for both construction as well as services.

Public Law 88-164 the Community Mental Health Facilities Community Construction Act of 1963 was landmark legislation. We urge that this program for prevention and care of the mentally ill be placed in full effect by enactment of H.R. 2985 with its provisions for grants for the initial cost of professional and technical personnel.

We would appreciate having this letter included in the record of the hearings.

Sincerely yours,

RUDOLPH T. DANSTEDT, *Director.*

UNITED MINE WORKERS OF AMERICA,
WELFARE AND RETIREMENT FUND,
Knoxville, Tenn., March 3, 1965.

HON. OREN HARRIS,
Chairman, House Commerce Committee,
House Office Building,
Washington, D.C.

DEAR MR. HARRIS: I am writing you about a health bill with which you are now concerned, H.R. 2987, the proposal that would make mortgage insurance and loans available for the construction and equipment of medical or dental group practice clinics.

I hope and believe you will agree that the combination of specialists and general practitioners in a group under one roof with all of the modern laboratory and X-ray equipment necessary makes for a better professional environment, and most important of all, makes possible continuous, efficient and effective diagnostic and therapeutic services for the patient at the most reasonable possible cost-

It is becoming increasingly accepted that the physician practicing alone and in isolation from his colleagues cannot deliver the kind of scientific medical care that is the product of our diligent research scientists.

Groups of physicians do not band together readily because of difficulties they suffer in obtaining finances, particularly for facilities. There are many other personal and traditional barriers to the formation of group practice and when the economic difficulty is added to the rest, the development of this scientifically necessary pattern is considerably deterred. The legislation in question will make the growth of this type of group service much more likely. Furthermore, consumer groups and nonprofit philanthropic organizations desiring to establish this kind of practice for the entire community's benefit will be in a much better position to obtain assistance if this legislation is passed.

There is a considerable advantage in having community rather than physician-owned facilities. This has been proven with respect to our voluntary hospital system with which you are quite familiar. If physicians own clinics, members of the group leave from time to time, and there is always a threat to the maintenance of the organization and its quarters. Furthermore, new physicians added to the group have to take on some of the burden of the cost of the facility and this makes recruitment much more difficult. When a nonprofit corporation provides the underpinning for the organization and its facility, the physicians are relieved of a great deal of worry and can concentrate on developing the kind of group care that is desired by their clientele.

I am sure you are quite familiar with the advantages of group practice and this legislation, and I cannot imagine any serious opposition to H.R. 2987. I am therefore hopeful that you will support this bill as you have backed other legislation of benefit to the health of all.

Yours sincerely,

ALLEN N. KOPLIN, M.D.,
Area Medical Administrator.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., March 3, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR MR. HARRIS: The American Nurses' Association, the professional organization of registered nurses, wishes to record its support of H.R. 2985, which will supply the necessary funds for initial staffing of the community mental health centers. This proposal was included in bills introduced in the 88th Congress but was deleted before the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 became law. Public Law 88-164 provided grants only for the construction of the centers.

The ANA supported the original proposal and urged your committee to do so in 1963. We now reiterate our support of this as proposed in H.R. 2985, an amendment to Public Law 88-164. We stated in our testimony of March 28, 1963, that "The success of programs to combat mental illness and mental retardation will be dependent in large measure on the availability of well-qualified professional manpower." As has been said repeatedly, by eminent individuals and by the ANA, in testimony on the Hill-Burton program, buildings alone do not constitute a program. Buildings provide only a setting in which treatment can be carried out. The provision of this treatment, however, is dependant upon personnel. Action for Mental Health clearly stated that the greatest need in mental health facilities is for professional personnel. No results can be attained unless there are skilled persons to treat the troubled persons who will come to the centers for help.

In consideration of the staffing needs for the community health centers, the ANA requests that consideration be given to the national contribution to be made

by psychiatric nursing personnel. As reported in the USPHS 1963 publication, *Nursing Careers in Mental Health*, "The relationship of the nurse and patient is recognized as increasingly important in psychiatric treatment, since recent developments have shown that emotionally disturbed persons respond favorably to the personal care and concern that are the special and unique contributions of the psychiatric nurse. A psychiatric nurse serves not only the physical needs of a patient but his emotional and social needs as well. The nurse's patience and compassion help to form a link with the world the patient has temporarily lost." Patients need nurses.

The community aspect of patient care has become an increasing concern of the professional nurses association. Current communications from the national organization to individual and groups of nurses emphasize the importance of nurses' extending their involvement in community projects at the local level. This emphasis is especially relative to the needs of the mentally ill and mentally retarded. This position was enunciated by the national nursing organization back in February 1959, when at the meeting of the ANA-NLN Coordination Council Committee on Meeting the Needs of the Mentally Ill, it was decided that:

"The ANA and NLN take whatever action is appropriate to explore, identify, and promote the role of professional nurses which results from the extension of mental hospitals into the community. Such action should include encouraging each State mental health authority to employ one or more professional nurses prepared in psychiatric nursing and mental health and authorize them to work with nursing staffs and faculties in general and psychiatric hospitals, public health nursing services, and universities, and to be members of the interprofessional team of consultants wherever such a team is organized."

The ANA therefore endorses H.R. 2985 to provide for Federal assistance for initial staffing of community mental health centers in order that the needs for the prevention, treatment, and rehabilitation of the mentally ill in the community will be met.

We ask that this communication be made a part of the committee record of hearings.

Sincerely yours,

JUDITH G. WHITAKER, R.N.,
Executive Director.

STATEMENT OF JERRY VOORHIS, EXECUTIVE DIRECTOR OF THE COOPERATIVE LEAGUE OF THE UNITED STATES OF AMERICA, IN SUPPORT OF H.R. 2987

Mr. Chairman and members of the committee, the cooperative league is a national federation of mutual insurance companies, group health plans, farmers' purchasing, supply and marketing cooperatives, rural electric cooperatives and consumers, housing, credit and other kinds of mutual and cooperative enterprise in our country. The heart of our work is promotion of the mutual, self-help voluntary method whereby groups of people can solve or begin to solve their problems by their own efforts. Our total membership is about 15 million.

The interest of the cooperative league in the pending legislation flows from our basic purpose, just stated. We believe that H.R. 2987 introduced by the distinguished chairman of this committee, is highly meritorious legislation.

It provides for insurance of—and in some cases the direct making of—loans for construction and equipment of facilities for the group practice of medicine and dentistry. The bill provides for priority of consideration to be given to nonprofit, and prepayment group practice plans and to facilities in rural areas.

Passage of the bill would give stimulus and encouragement to voluntary action on the part of both consumers and providers of medical care.

There is a serious drift of doctors away from the smaller communities of the country. This is caused in large part by the fact that modern doctors want modern facilities in which to work. Under this bill it would be possible for the people of rural communities to provide such facilities and thus to bring doctors back to their communities.

Modern medicine can accomplish what are near miracles of leading. But one feature of the remarkable progress which medical science has made is the growth of specialization. Another is the sharply rising cost of hospital and medical care. The average family, not to mention the low-income one, can neither find its way to just the right specialist nor pay the cost of the medical care it needs on an emergency fee-for-service basis. This is why group practice, by balanced teams of family doctors and specialists, should be encouraged as this bill would do. It is also the reason why an orderly method of payment for preventive as well as curative care is required if our people are to be able to pay for the best of modern medical care. The priorities in the bill would encourage this also.

Several million people in the United States are receiving comprehensive medical and health care at costs they can afford because they have formed cooperative community or labor health plans. There doctors practice in groups, costs of preventive and curative care, when needed are prepaid by the subscribers, and the doctors and their patients work together to keep people well. This is good economy—for the people and for the Nation. It reduces sharply the need for hospitalization, which is the highest cost item of all. Some 5 million of these people are members of the voluntary health plans which are affiliated with Group Health Association of America.

This kind of voluntary action by the people certainly deserves not only commendation but encouragement. This bill H.R. 2987 would give them that. There are many rural communities where group practice plans would be formed if only they could see where they could get the funds for their needed facilities. And where voluntary health plans are already in operation the need very often for additional facilities is so acute that they must refuse to admit new members.

This bill would, in practical effect, set up an FHA (Federal Housing Administration) for health facilities. It would provide the loan insurance for health facilities which FHA has, with such fine results, provided for home construction—at no cost to the Government whatsoever. The only difference is that the need is even greater in the case of the group practice facilities because health facilities are one-purpose structures and conventional financing is for that reason very difficult and in some cases impossible to obtain.

The direct loan provisions of the bill are important and necessary, too, because there will be cases where even the guarantee of loans will be insufficient inducement to lenders. This will be especially true in rural areas.

H.R. 2987 is a good bill. It is a badly needed bill. It will encourage voluntary action by the people in solving the very pressing problems of health economics. It is hoped that this committee will report the bill favorably and that it can be promptly enacted into law.

TESTIMONY IN SUPPORT OF H.R. 2985 ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, BY ARTHUR H. BRAYFIELD, PH. D., EXECUTIVE OFFICER, FORMERLY CHAIRMAN, PSYCHOLOGY DEPARTMENT, PENNSYLVANIA STATE UNIVERSITY; CHAIRMAN, PSYCHOLOGY DEPARTMENT, KANSAS STATE UNIVERSITY

In recent years Congress has established a distinguished record of leadership in promoting the general welfare through efforts to increase the effectiveness of our people. These efforts have been given substance through "milestone" legislative enactments in the areas designated as education, health, and welfare. Today, we have reached the understanding that all three areas are intimately bound up in the concept of human effectiveness or of mental health.

One expression of this understanding was the national mental health legislation of 1963 which gave substance to the concept of comprehensive mental health services. Embodied in this legislation was the vision of a truly focal point for community action to develop and conserve our precious human resources. In such community centers, we all hope, will be found a mobilization and mustering of facilities and talent to provide many kinds of services for many different aspects of developing human resources. Many psychologists are joining with other professional persons and with citizens in planning these so they will become major sources of hope and help for distressed individuals. In these community services we hope that both child and adult can learn or relearn the ways of adaptive behavior and mobilize and muster his own personal resources for an effective and satisfying life.

Hopefully, the new community centers will give ample range for local innovation and for imaginative patterns of operation, of location, of staffing, of sponsorship, and of affiliations with other agencies. The predominance of any one pattern, be it State institution or general hospital model, would be retrogressive and a barrier to experiment and innovation. The psychologists for whom I speak today would like to see these community services continue to grow away from the old patterns, away from the limitations of the old State hospital, and even away from any narrow view of these problems as falling in the "domain" of any one or two professions. These are truly community problems and must be approached with the help of all of a community's leadership.

It is remarkable that before your committee the AMA opposes this "staffing" while at NIMH other M.D.'s (as in sec. 54.212, par. C,2 of the administrative regulations for title II, Public Law 88-164) seek to insure that "if staffing goes through" the top man in these things must always be an M.D. We believe competence, not label, should be the guide, and social work, psychology or the law, or other professions may provide leadership for many aspects of community mental health services. In this respect we are pleased to see that the proposed amendment places no restrictions as to administration of these centers, and does not assume that an M.D. must be placed in charge.

Three factors importantly affect the successful achievement of the objectives of the comprehensive community mental health center approach.

First—the centers must be free from restrictions which dampen or thwart the emergence of new patterns of service. They must be attractive to imaginative professional persons.

Second—the centers must be free to take advantage of demonstrated leadership capability from whatever source it may come—medical or nonmedical.

Legislation designed to increase the supply of manpower for mental health should not be interpreted by administrative regulations to reduce the supply of effective manpower.

If the emerging State plans and the existing NIMH regulations meet these reasonable tests, the centers will provide the conditions necessary to attract and retain highly qualified mental health professionals.

Under these conditions of exciting new programs and challenging opportunities for leadership and service, the provisions of H.R. 2985 become the crucial third factor in the success of the centers. Initial staffing support becomes the key ingredient.

The 50 State psychological associations which are constituent parts of the national organization are intimately concerned with this new legislation as many Members of the Congress already know. Our national body, the American Psychological Association, commends H.R. 2985 to you and urges favorable action upon it by this committee and by the House of Representatives. The Congress has set our feet on the right path—let us now proceed with the impetus afforded by initial operational support.

We thank you for the opportunity to make this statement.

STATEMENT OF HENRY W. HOFSTETTER, O.D., PH. D., DIRECTOR, INDIANA UNIVERSITY, DIVISION OF OPTOMETRY, ON BEHALF OF THE AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman and members of the committee, on behalf of the American Optometric Association, pursuant to the unanimous action of its board of trustees, of which I am a member, I have been authorized and directed to submit the following statement in support of the enactment of this legislation with 14 amendments to H.R. 2987 when the bills are reported to the House.

In addition to being a member of the Board of Trustees of the American Optometric Association, I am director of the Division of Optometry at Indiana University, and a past president of the Association of Schools & Colleges of Optometry.

The American Optometric Association is a voluntary, nonprofit organization, with a total membership of approximately 13,000 distributed through 50 States and the District of Columbia. There are some 18,000 practicing optometrists in this country, who provide vision care for the great majority of Americans.

In order to practice, every optometrist must be licensed in the jurisdiction where he practices. To secure a license, he must be a graduate of an accredited

school or college of optometry and the minimum requirements are 2 years of pre-optometry study at the college level and 3 to 4 years of professional study. In addition, he must pass a rigid State board examination. There are at present 10 schools and colleges of optometry in the United States. All of them are accredited by the Council on Optometric Education which, in turn, is affiliated with the National Commission on Accreditation.

At Indiana, one of our outstanding programs is in the field of highway safety. This committee is well aware of the tragic toll of lives, crippling injuries and property damage that is taken annually on our highways.

The March 1, 1965, issue of U.S. News & World Report contains an article dealing with this subject. It estimates that for 1965 each week a thousand lives will be lost and 35,000 injured on our highways.

The Federal Register for February 26, 1965, contains a memorandum and supporting statement by President Johnson calling upon the heads of executive departments and agencies to conserve manpower by improving their safety standards and on February 24 the President issued his second annual Save Your Vision Week proclamation, calling upon all Americans to join in programs for the conservation of vision.

Our association has a committee on research, of which Dr. William R. Baldwin, dean of Pacific College of Optometry, Forest Grove, Oreg., is the chairman.

We also have a committee on motorist's vision and highway safety, of which Dr. Robert J. English of Dillon, Mont., is chairman. Two consultants to this committee are Prof. Merrill J. Allen of the Indiana University optometric faculty and Prof. Glenn A. Fry, dean of the School of Optometry of the Ohio State University.

Other committees which have been involved in research programs are the committee on vision care of the aging, the visual problems of aeronautics and space, the visual problems of children and youth, the committee on visual aid to the partially sighted, the committee on orthoptics, and the committee on occupational vision.

Our association sponsored a national conference on optometric research. It was held in the Nation's Capital and attended by some 75 leaders in the field of research related to vision.

Our profession makes a substantial contribution to visual research through the American Optometric Foundation, but if we are to realize the full potential of optometric research, more funds must be made available through the Public Health Service Act.

We are particularly interested in the new section 712, which would provide for construction and operation of specialized regional or national facilities. In this connection, permit me to call attention to the optometric centers in a number of our leading cities. The first was the Optometric Center in New York. It was organized several years ago to take the place of a free clinic which had been conducted by the School of Optometry at Columbia University, but which was discontinued some years ago. Since then it has developed a service which is indispensable to the visual welfare of literally tens of thousands of New York's citizens who are in need of vision care but unable to afford it. It is serving the old and the young, without regard to race or creed. There is a similar center in the District of Columbia.

The bill would abolish the Office of Special Assistant to the Secretary (Health and Medical Affairs) in the Department of Health, Education, and Welfare and create three additional Assistant Secretaries for the Department. While the bill does not so provide, it seems logical that one of the additional Assistant Secretaries might fall heir to the designation (Health and Medical Affairs). We, therefore, suggest that it might be well for Congress to designate one of the new Assistant Secretaries for Health, leaving out the words "Medical Affairs." You are all aware of the ill-considered attitude which the AMA has taken toward the optometric profession and which quite automatically bars optometric participation in any project for which the title is "modified by," or designated, "medical."

We are fully cognizant of the great contribution which the medical profession has made to the health of the American people, but at the same time, we are particularly well aware of some of the disservice that has been rendered by the edict of the AMA House of Delegates when it declared it unethical for any of its members to collaborate professionally with an optometrist. The visual welfare of the American public demands that the two professions collaborate when it is

in the interest of thier patients. This has been demonstrated conclusively in the armed services, where some 450 optometrists are on active duty in commission status. In the Navy, optometrists were commissioned shortly before Pearl Harbor and in the Army and Air Force after the passage of the Medical Service Corps Act in 1947. Notwithstanding this, the AMA still contends that the services performed by optometrists should either be performed by physicians who are indeed in short supply or by technicians, referred to in the Army during World War II as "90-day wonders." When the tragic results of that program in the Army were aired before committees of Congress, prior to V-J Day, in spite of the opposition of the War Department and the AMA, both the House and Senate passed, unanimously, a bill to establish an optometry corps in the Army, composed of commissioned optometrists. The bill was vetoed by President Truman only because the war was drawing to a close and the Army had agreed to sponsor legislation such as the Medical Service Corps Act, which included commission status for optometrists.

As a result of the 1950 amendment to the aid to the blind program under title X of the social security law, ophthalmologists and optometrists for the first time were compelled to cooperate in the optical aids service of the Industrial Home for the Blind in Brooklyn, N.Y. The first 500 cases covered a period from March 1953 to December 1955. A survey was published by the home in 1957, from which I should like to quote—first from the commentary by Richard E. Hoover, M.D., ophthalmological consultant:

"All clients must have had a previous ophthalmological examination and a determination of blindness within the legal definition before they can register for the optical aids service.

"This program could not have attained the popularity which it enjoys and the success indicated in this report without the support, sincere interest, and capabilities of the director, the ophthalmologist, the optometrist, and the service and administrative personnel who gave encouragement, instruction, and help in the use of the aids.

"A much needed service has been rendered!" [Italics supplied.]

Again, I would quote from Leo Esbin, M.D., staff ophthalmologist:

"As an ophthalmologist I have watched with keenest interest the development of the optical aids service at the Industrial Home for the Blind, the more so that the 500 clients served were persons who, on the basis of an ophthalmological examination, were found to come within the legal definition of blindness. All of them had had ophthalmological service—some of them very extensive service over a period of years—and most of them had been told that nothing more could be done to improve their vision.

"Against this background, it was surprising to find that 68 percent of the group had obtained a useful increase in visual acuity through the use of optical aids. Even though the increase be small in itself, and even though most of these individuals remain within the legal classification of 'blind,' it is apparent from the report that the opportunities for employment, for recreation, and for personal independence, which have been opened up for them are far from insignificant.

"The IHB has rendered a real service in the field of work with the blind, not only by its demonstration of what can be accomplished, but also by this informative report in which factual and statistical data provide the basis for constructive and forward-looking conclusions. It has been a privilege to participate in this program."

I would also like to quote from the commentary of the staff optometrist, G. Ottenheimer Hellinger, O.D.:

"The success of the first program established anywhere for the rehabilitation of the near blind by means of optical aids is due mainly to the courage and foresight of IHB's executive director, Peter J. Salmon. It is largely owing to his efforts that the virtual elimination of the differences between optometrists and ophthalmologists concerning the use of telescopes and microscopes has been accomplished. There are now very few, if any, ophthalmologists who still believe that the use of the eyes in low-vision cases or in arrested pathology is contraindicated.

Through experience in wrestling with vision problems and with the needs of near-blind patients and patients with subnormal vision here and in my office, it became obvious that the conventional eye examination technique and standards or response must be both modified and extended to new ranges and visual habits. The new optometric approach is to give aid no matter how small it may appear in

relation to normal sight, and to demonstrate to the patient what he can see rather than what he cannot.

The gratifying results achieved here with the complete cooperation of the other professions involved, indicate the tremendously valuable aid that is possible to the near-blind. I am very happy and proud to have been a part of this experiment."

H.R. 2985 pertains to mental health centers. Not all but many persons suffering from mental-ill health are also suffering from impaired vision. To improve their vision in many of these cases would improve their mental health and, therefore, I want to call the committee's attention to the fact that optometry can make a contribution by providing appropriate and otherwise unavailable personnel for these mental health centers.

It is with reference to H.R. 2987 that I desire to suggest some amendments. More and more optometrists because of specialties in the practice, such as contact lenses, visual training, orthoptics, industrial vision, vision care of both the young and the old, find it desirable to engage in group practice. We see no reason why optometry should be excluded from H.R. 2987. Therefore, we respectfully suggest that the bill be amended so as to make its provisions applicable to group practice by optometrists. A list of the proposed amendments is attached to the statement.

PROPOSED AMENDMENTS FOR H.R. 2987

1. Amend the title by inserting after the word "medicine" the word "optometry."
2. Page 1, line 9, after the word "medicine," insert the word "optometry."
3. Page 1, line 10, after the word "medical," insert the word "optometric."
4. Page 2, line 5, after the word "dentists," insert the word "optometrists."
5. Page 17, line 25, after the word "medicine," insert the words "or optometry."
6. Page 18, line 4, after the word "medical," insert the word "optometric."
7. Page 18, line 5, after the word "medical," insert the word "optometric."
8. Page 18, line 7, after the word "medicine," insert the words "or optometry."
9. Page 18, line 23, after the word "medical," insert the word "optometric."
10. Page 18, line 24, after the word "medical," insert the word "optometric."
11. Page 18, line 25, after the word "medical," insert the words "or optometric."
12. Page 19, line 6, after the word "medical," insert the word "optometric."
13. Page 19, line 11, after the word "medical," insert the word "optometric."
14. Page 19, line 13, after the word "medical," insert the word "optometric."

STATEMENT OF BRIDGEPORT (CONN.) AREA MENTAL HEALTH ASSOCIATION

Mr. Chairman and members of the committee, I am John Grabau, president of the Bridgeport Area Mental Health Association, and a local businessman in that area.

On Thursday, March 4, Governor Dempsey referred to Bridgeport's population of 150,000 and my area including 5 adjacent towns totaling 291,000 people, when he spoke of the proposed site of a mental health center allocated for in his present budget. As Governor Dempsey mentioned, our only facilities presently are: one mental health hospital 25 miles out of town, literally in the hills, with an out-patient clinic, and a child guidance center reputed to be one of the finest in the country. We do not have one single hospital bed in the area for psychiatric use.

My purposes in being present at the hearing last Thursday and Friday were: (1) To give support, of course, to H.R. 2985; (2) through statements and facts submitted to try and give you a better insight to the local area that would benefit from the initial staffing of its community mental health center; (3) to dispel any belief that by the Federal Government assuming responsibility for the initial staffing it will lessen the interest, obligation, or sense of responsibility of the people in the community. On the contrary, it would permit the community to more quickly house and staff psychiatric units and outpatient clinics in the general hospitals. On a statewide basis, it would benefit expedient construction of more mental health centers where needed.

A question that might be raised because of Federal aid being available for initial staffing and because there is a dearth of services in the area, is there a mandate from the people and are they responsible citizens?

In a referendum in one of the five surrounding towns 1 month ago, the people voted two to one against \$5 million in Federal funds on a matching basis for

redvelopment. Many of these same people joined better than 30,000 citizens in signing a petition in support of the construction of a mental health center. More than 75 citizens drove 75 miles to the State capitol to appear at the legislative hearing. Over 300 citizens appeared at a midweek luncheon representing the whole of the community: unions, professions, businesses, clergy, social organizations, service clubs and the like to discuss a comprehensive mental health plan.

Since that time more than 14 committees have been meeting to discuss specific mental health problem areas and in a final report to be released next month recommendations will be made for a comprehensive regional mental health plan.

The Bridgeport Post last May was one of two newspapers in the country awarded a citation for their outstanding support in the fight against mental illness.

The people of my area are typical American citizens. We don't expect the Federal Government to do the job for us, nor are we naive enough to believe that the center is the complete answer to our regional problems. Together with two of our three general hospitals having psychiatric units by 1970 and the third making plans, we will have the facilities to cope adequately with the problem. Only with Federal aid to initially staff the center can we see a smooth start.

On behalf of the BAMHA I would like to thank you for the opportunity of submitting this statement to you.

STATEMENT OF CARL E. MORRISON, D.O., ON BEHALF OF THE AMERICAN OSTEOPATHIC ASSOCIATION ON H.R. 2984, H.R. 2985, H.R. 2986, and H.R. 2987

My name is Dr. Carl E. Morrison. I am engaged in active practice at the Rincon Osteopathic Clinic, in Tucson, Ariz. In my capacity as chairman of the Council on Federal Health Programs of the American Osteopathic Association, I am pleased and honored to express our views on the pending bills, H.R. 2984, H.R. 2985, H.R. 2986, and H.R. 2987.

H.R. 2984

The association supports H.R. 2984, cited as the Health Research Facilities Amendments of 1965. This bill would extend for an additional 5 years and expand the matching grant program first authorized in 1956 for the construction of facilities for the conduct of research in the "sciences related to health" defined in the act of 1956 as "medicine, osteopathy, dentistry, and public health, and fundamental and applied sciences when related thereto."

The osteopathic institutions have had limited participation in this program principally because of the restrictions of use of research space and high matching requirements. We hope both can be liberalized.

Increasing research activities in the osteopathic colleges has created an acute need for expansion of facilities. Grants from the research fund of the American Osteopathic Association are made annually in support of research projects. A growing backlog of applications has accumulated. In excess of \$93,000 was disbursed from this research fund during the first 6 months of 1964-65, at reduced support because of lack of funds, examples of which are the following ongoing projects:

A study of nerve muscle transmission by electron and fluorescence microscopy.

The influence of sustained hyperactivity in spinal afferent pathways on spinal neural elements.

Continued studies in somatic-autonomic interchange and related phenomena. Neural and spinal reflex components in various disease processes.

Functional characteristics of normal and abnormal body mechanics and related activities.

Electrophysiological and histochemical studies of the spinal cord.

Resistance of rats to stressful situations.

Morphological neurohumoral and congenital consequences of experimental lumbar lesions.

The influence of mobilization of the lungs and thorax on pulmonary function.

The structural, functional, and chemical effects of foreign innervation on stirred muscle—a preliminary study in trophic mechanisms.

Studies on the origin of erythropoietin.

Support of research programs in the osteopathic colleges by the National Institutes of Health is of inestimable importance, as illustrated in the following chart:

Osteopathic grants and awards by the National Institutes of Health, fiscal year 1963

[Source: Research Grants Index (PHS No. 925, vol. 2) and Training Grants (PHS No. 1079, pt. 2)]

RESEARCH GRANTS

College	Investigator	Project title and publication	Grant No.	Review group	Amount
CCO-----	Kelso, A. F.----- Melchoir, J. B.-----	General Research Support. Enzymology of Potassium Ion. Fed. Proc. 22:360, 63. Inhibition of yeast hexokinase by magnesium ion.	FR-15136-1----- GM-10094-1-----	NSS PC	\$35,493 8,625
COMS-----	Niffenegger, J. B.----- Bunce, Donald----- Celandier, D. R.-----	General Research Support. Structural analysis of the distended arterial wall. Use of urokinase in study of the fibrinolytic system. Biosynthesis and use of Se-75 proteins as tracers. Fed. Proc. 22:619, 63. Characterization of fibrinolytic activity of vascular intima.	FR-15137-1----- HE-07669-2----- HE-07669-1S1----- AM-06285-2----- HE-07260-3-----	NSS PATH PATH HEM HEM	32,475 10,928 3,859 11,701 10,794
	Goldie, Mark-----	Development of phenocopies in the chick embryo. Am Zool 2:411, 62. Development of the rumpless phenocopy in chick embryos treated with boric acid.	GM-08505-----	GEN	6,282
KCCOS-----	Cole, W. V.----- Sandage, C. N.-----	General Research Support. Abrogation of tumor stain specificity of mucin.	FR-15138-1----- CA-07798-2-----	NSS PATH	36,152 18,227
KCOS-----	Denslow, J. S.----- Dun, F. T.----- Hix, E. L.-----	General Research Support. Reflex and postural muscle contraction. Transmission and interaction of nerve impulses. Reflex and trophic functions of kidney innervation. Fed. Proc. 21, No. 2, 62. An apparent trophic function of renal nerves.	FR-05139-1----- HE-01956-8----- NB-02907----- AM-01761-6-----	NSS PHY PHY PHY	56,319 2,919 11,500 17,106
PCO-----	Mercer, S.-----	General Research Support	FR-05140-1-----	NSS	30,524
Total-----					292,904

TRAINING GRANTS

College	CA	HE	MH	NB	Totals
CCO-----	\$25,000	\$25,000	\$22,776	\$21,705	\$94,481
COMS-----	25,000	49,000	33,308		107,308
KCCOS-----	25,000	25,000	18,888		68,888
KCOS-----	25,000	25,000	17,592		67,592
PCO-----	25,000	25,000	15,000		65,000
Total, training grants-----					403,269
Total, research grants-----					292,904
Grand total-----					696,173

Glossary: FR=Division of Research Facilities and Resources; GM=General Medical Sciences (Institute); AM=Arthritis and Metabolic Diseases (Institute); CA=Cancer (Institute); NB=Neurological Diseases and Blindness (Institute); MH=Mental Health (Institute); NSS=Interdisciplinary; PC=Physiological Chemistry; PATH=Pathology; HEM=Hematology; GEN=Genetics; PHY=Physiology; HE=Heart (Institute).

H.R. 2985

We are sympathetic with the objective of H.R. 2985, cited as the Community Mental Health Centers Act Amendments of 1965. This bill authorizes Federal assistance for defraying part of the costs for professional and technical personnel required for initial staffing of the community mental health centers approved under Public Law 88-164.

There is a recognized shortage of the professional personnel available, and these newly constructed community mental health centers may well need help in competing for the staff indispensable to their operation.

The training grant programs of the National Institute of Mental Health, in which the osteopathic colleges participate as shown in the above chart of NIH training grants, serve to emphasize and improve mental health training of medical and osteopathic students and to encourage an increasing number of seek additional training. The demand for graduate training of osteopathic physicians in this field far exceeds the supply.

H.R. 2986

We support the bill H.R. 2986, cited as the Community Health Services Extension Amendments of 1965. This bill would extend the program of grants under the Vaccination Assistance Act of 1962 (Public Law 87-868) for immunizations against polio, diphtheria, whooping cough, and tetanus for the 5 fiscal years 1966-70 at an annual appropriation sufficient for the purpose, and add measles to the program. Under the legislation Federal funds may be used only for the purchase of vaccines for preschool children, for the expenses of additional State and local personnel required for planning, organizing, and promoting immunization programs, and for additional epidemiologic and laboratory surveillance activities.

The bill also extends to June 30, 1970, the program of grants for family health service clinics for domestic agricultural migratory workers authorized by an amendment (Public Law 87-692) to the Public Health Service Act. We understand that during the 3 years of the program, project grants have been awarded to share in the costs of providing public health services in 100 counties, and that these services include immunizations, prenatal and postnatal clinics, dental services, and case finding for such diseases as tuberculosis.

This bill also extends for an additional year the program of project grants for community health services authorized by the Community Health Services and Facilities Act of 1961 (Public Law 87-395).

H.R. 2987

We agree with the pronouncement in H.R. 2987 that group practice offers great promise of improving the quality of medical care.

A statistical study of the osteopathic profession as of December 31, 1963, by the American Osteopathic Association showed out of 9,731 survey returns of private practitioners, 1,227 physicians D.O. were engaged in small partnership practice and 450 were in group practice.

The bill authorizes mortgage insurance and loans to help finance the cost of constructing and equipping facilities for group practice. The Surgeon General of the Public Health Service, upon application by a qualified mortgagee would be authorized to insure the mortgage in an amount not exceeding 90 percent of the value of the property or project when construction is completed, for a term not to exceed 25 years with complete amortization through periodic payments.

The bill defines a group practice facility as a facility for the provision of preventive, diagnostic, and treatment services to ambulatory patients in which the patient care is under the professional supervision of persons "licensed to practice medicine in the State."

A medical group is defined in the bill as a partnership or other association or group of persons "licensed to practice medicine in the State" who engage in the coordinated practice of their profession primarily in one or more group practice facilities.

The term "medicine" as used in the above mentioned definitions of "group practice facility" (line 25, p. 17 of the bill) and "medical or dental group" (line 7, p. 18), may be construed to include persons licensed to practice osteopathy and surgery, but in order to make clear this intention we feel that the words "or surgery" might well be added after the word "medicine" in both cases. Such clarification would be in consonance with the format established in previous legislation, specifically, the definitions of "diagnostic or treatment center," "rehabilitation facility," and "nursing home" in the Medical Facilities Survey and Construction Act of 1954, Public Law 482, reenacted in the Hospital and Medical Facilities Amendments of 1964, Public Law 88-443.

When the above Public Law 482 was under consideration by the House the following interchange as recorded page 2789 of the Congressional Record of March 9, 1954, took place:

"Mr. ROGERS of Florida. Mr. Chairman, I offer an amendment.

"The Clerk read as follows:

" 'Amendment offered by Mr. Rogers of Florida.

" 'Page 14, line 24, after the word "medicine" insert the words "or surgery".

" 'Page 15, line 14, after the word "medicine" insert the words "or surgery".

"Page 15, line 24, after the word "medicine" insert the words "or surgery".

"Mr. WOLVERTON. I would like to inform the gentleman that so far as the membership of the committee on this side of the aisle is concerned, we have no objection to the amendment that has just been offered.

* * * * *

"Mr. HARRIS. What the gentleman proposes to do here is to include the word "surgery" in the definition of diagnostic centers and so forth, which would apply to this part which would be part G of the Public Health Act.

"Mr. ROGERS of Florida. That is correct.

"Mr. HARRIS. We provided in the definition that diagnostic centers, and so forth, may be operated in connection with the hospital. Now, that meant that if such a facility was constructed in connection with a hospital, the supervision of persons licensed to practice medicine would actually be available; is that not true?

"Mr. ROGERS of Florida. That is true.

"Mr. HARRIS. And the committee thought that in these facilities that would not be related to hospitals, that there should be some medical attention available, and that is the reason this definition was provided as it is; is that not true?

"Mr. ROGERS of Florida. I do not know whether they intended to restrict it entirely.

"Mr. HARRIS. Well, that is what we did, and what the gentleman is doing here is providing that the osteopathic centers in the States may not only get the provisions of the original Hill-Burton Act, but any States where they are licensed to practice osteopathy and surgery.

"Mr. ROGERS of Florida. I think that is the intention.

"Mr. HARRIS. And that is the intention of the amendment.

"Mr. ROGERS of Florida. Yes. Will the gentleman accept it?

"Mr. HARRIS. As far as I am concerned, it is perfectly all right.

"Mr. ROGERS of Florida. I do not want to take up the time of the House if the gentleman accepts it. I like to speak, but I do not like to speak that much.

"The CHAIRMAN. The question is on the amendment offered by the gentleman from Florida (Mr. Rogers).

"The amendment was agreed to."

We hope for like clarification of H.R. 2987.

Information on specialization by osteopathic physicians and surgeons is contained in Public Health Service Publication No. 263, Health Manpower Source Book, section 14, "Medical Specialists," page 233, as follows:

"Physicians (M.D. and D.O.).

"The number of full- and part-time specialists in each type of specialty is summarized in table 20 for medical and for osteopathic physicians. Osteopathic physicians accounted for 1 percent of the 131,000 full-time specialists but as much as 14 percent of the 15,000 part-time specialists.

"The choice of specialty is somewhat different between the two, as shown by the proportion in each specialty field:

"[In percent]

	"Full-time specialists		Part-time specialists	
	M.D.	D.O.	M.D.	D.O.
Type of specialty: All specialties.....	100.0	100.0	100.0	100.0
Medical specialties.....	32.1	23.4	23.6	21.3
Dermatology.....	2.0	2.1	1.9	1.0
Internal medicine ¹	22.0	17.6	14.9	16.2
Pediatrics.....	8.1	3.7	6.8	4.1
Surgical specialties.....	45.3	63.5	64.4	68.0
Anesthesiology.....	4.3	10.9	6.3	9.6
Obstetrics-gynecology.....	9.0	6.9	14.5	16.0
Ophthalmology-otolaryngology.....	8.4	13.7	4.2	4.8
Surgery ¹	20.8	29.5	37.7	36.4
Urology.....	2.8	2.5	1.7	1.2
Psychiatry-neurology.....	9.5	3.0	3.8	2.6
Other specialties.....	13.1	10.1	8.2	8.1

¹ And related specialties.

"Among the full-time specialists, relatively more of the osteopathic physicians were in the surgical specialties, particularly in anesthesiology and in ophthalmology-otolaryngology. Relatively more of the medical physicians were in the medical specialties, primarily in internal medicine."

We appreciate this opportunity of bringing our views to this committee.

HON. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee
House of Representatives, Washington, D.C.:

We understand that your committee is meeting in executive session to consider several administration health measures, including H.R. 2987, the Group Practice Facilities Act. We believe that the principle of Government mortgage insurance and Government loans to assist responsible organizations in financing group practice medical facilities as proposed in H.R. 2987 is in the national interest because responsibly operated group practice plans, such as ours, have lower hospital utilization and provide preventive care resulting in lower cost for good health. We know from our experience that it is very difficult for group practice prepayment organizations to obtain private financing for such facilities unless they are supported by strong financial guarantors or have become well established and by experience have demonstrated their financial ability.

Sincerely,

EDGAR F. KAISER,
President, Kaiser Foundation Health Plan.

SHAWNEE COUNTY ASSOCIATION FOR MENTAL HEALTH,
Topeka, Kans., March 4, 1965.

HON. CHESTER MIZE,
House of Representatives, Washington, D.C.

DEAR MR. MIZE: As program director of this association I want to tell you of our interest in seeing that H.R. 2985 is passed. Will you please make our desire known to the House Interstate Commerce Committee.

Thank you for your attention to this matter.

With every good wish, I am,

Sincerely yours,

MARGARET L. STONE, *Director.*

THE GEARY COUNTY ASSOCIATION FOR MENTAL HEALTH,
Junction City, Kans., March 4, 1965.

HON. CHESTER MIZE,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN MIZE: The Geary County Association for Mental Health wishes to express to you and through you to the Interstate Commerce Committee its interest in House bill 2985, which we understand would provide for Federal matching funds to help staff community mental health centers.

Geary County is fortunate in having membership in the four-county North Central Kansas Guidance Center located at Manhattan, which started several years ago as a one-county operation and has managed as it grew to secure and hold adequate staff on its tax allotment plus fees. Many centers in Kansas, however, have not been able to secure a complete staff because of lack of funds. We believe that most of these if given a start initially might later become locally supported centers.

The Geary County Association for Mental Health along with the Kansas Association for Mental Health would like to see all of Kansas and the United States as well served by properly staffed community health centers. We believe that Federal matching funds in staffing as well as in building can help make this dream a reality.

Very sincerely,

M. L. WISBY, D.O., *President.*

THE MENNINGER FOUNDATION,
Topeka, Kans., March 5, 1965.

Hon. CHESTER MIZE,
House of Representatives,
Washington, D.C.

DEAR MR. MIZE: I understand the House Interstate Commerce Committee is currently considering House bill 2985 which would provide matching Federal funds for staffing community mental health centers.

The Kansas Psychiatric Society and the American Psychiatric Association advocate the passage of this bill. To provide money for the building of the mental health centers without a staffing provision would render these centers ineffectual. In Kansas, most of the counties levy taxes locally to provide support for these community centers, but these funds are totally inadequate to support the needed staff to provide local services for those in need.

I hope you will convey my interest in having this legislation passed to the House Interstate Commerce Committee.

Sincerely yours,

HERBERT KLEMMER, M.D.,
Delegate of the Kansas Psychiatric Society to the Assembly of the American Psychiatric Association.

THE LOS ANGELES SOCIETY OF CLINICAL PSYCHOLOGISTS,
Los Angeles, Calif., March 23, 1965.

Hon. EDWARD R. ROYBAL,
House of Representatives,
U.S. Congress, Washington D.C.

DEAR REPRESENTATIVE ROYBAL: I am writing to you in response to S. 513 and H.R. 2985 which are now pending before Congress. These bills are designed to provide funds for the staffing of federally supported community mental health programs. My constituents in the Los Angeles Society of Clinical Psychologists support the intent of the staffing bills but would urge their amendment in certain significant ways which I shall describe below.

The whole entry of the Federal Government into the organization and financing of community mental health programs is a direct outgrowth of the recommendations of President Kennedy's Joint Commission on Mental Health. The Joint Commission, in its precedent-shattering report, urged that the Federal Government throw its resources behind a massive program aimed both at encouraging bold new approaches to the solutions of mental health problems and at providing improved mental health care for the Nation's citizens. The Joint Commission, further, recognized that each of the core mental health professions (psychiatric nursing, psychiatry, psychology, and social work) had a vital contribution to make to mental health programs. Finally, the Joint Commission strongly urged that staff positions within the recommended programs be filled with persons possessing the relevant training, skills, competence, and experience to accomplish their duties without regard to the particular profession from which they were drawn.

Yet events of the past few years have served to jeopardize the spirit of the Joint Commission's proposals. The medical profession, in particular, has moved to assert its preeminence in the field of mental health at the expense not only of the other professions, but of the public interest, also. Lobbying independently in each of the States and through its position of authority within the National Institute of Mental Health, the medical profession has systematically attempted to formulate administrative regulations which would:

(1) Expand existing mental hospital facilities to service community mental health needs. Many recognized authorities in the field have begun to question the helpfulness of sending disturbed patients to the huge, bureaucratized, impersonal mental hospital. We need fewer not more of these. But the mental hospital is a setting where the medical profession occupies a position of entrenched authority and could now extend that control.

(2) Establish staffing patterns and role responsibilities in mental health centers which would clearly and without pretence make the other professions ancillary to and the handmaidens of medicine. The social worker, the psychiatric nurse, and the psychologist could not then make their optimal contribution within an atmosphere which would deprive each of professional independence.

S. 513 and H.R. 2985, then, are vital and should be passed by Congress. Their language, however, should reassert the principles of the Joint Commission's

recommendations. Somewhere in their provisions, it should be made clear that communities are to be encouraged to experiment with new patterns of mental health care and that a variety of outpatient settings could be the bases for the establishment of community mental health centers. Legislation should also make unequivocal the proposition that the staffing of positions within the federally supported mental health programs (whether the position in question be an administrative, policy-determining or a clinical one) be accomplished solely on the basis of competence. That is, individuals to man the program should be selected according to their training, experience and potential contribution and not according to the profession from which they have been drawn. It should be specifically noted that some members of each of the core mental health disciplines (psychiatric nursing, psychiatry, psychology, and social work) have the competence required in any such positions or roles. If pending legislation would make these points of view clear, it would stand as a reassertion of the rights of the people over those of any narrow interest groups.

Sincerely,

ARTHUR L. KOVACS, PH. D., *President.*

LOS ANGELES COUNTY PSYCHOLOGICAL ASSOCIATION,
Los Angeles, Calif., March 22, 1965.

HON. EDWARD R. ROYBAL,
*House of Representatives, U.S. Congress,
House Office Building, Washington, D.C.*

DEAR REPRESENTATIVE ROYBAL: This is in regard to H.R. 2985 before the Congress of the United States.

In the early 1960's President Kennedy's Joint Commission on Mental Health advocated that the Federal Government throw its resources behind a massive program aimed both at encouraging both new approaches to the solutions of mental health problems and at providing improved mental health care for the citizens of the Nation. The Joint Commission's recommendations were received with great appreciation by lay people and professionals knowledgeable in this area. In its precedent-shattering conclusions, the Joint Commission recognized that the various core mental health disciplines (psychiatric nursing, social work, psychology, and psychiatry) all had unique and significant contributions to make to administration, research, training, and service. It was the Joint Commission's recommendation that the staff positions within the contemplated Federal mental health programs should be filled with persons possessing the relevant training, skills, competence, and experience to accomplish their duties without regard to the particular profession from which they were drawn.

In 1963, Congress heard bills allocating funds for Federal participation in mental health programs. A bill making funds available for the construction of mental health centers was eventually passed although sections having to do with the financing of staff positions were dropped (partly because of disagreements between the American Medical Association and the American Psychiatric Association).

Within the past 2 years, the National Institute of Mental Health, in anticipation of final affirmative action by Congress, has evolved a set of regulations to serve as guidelines for local government for the development and staffing of such community mental health centers. NIMH, however, is an agency under medical direction. Its proposed regulations do violence to the spirit of the Joint Commission's recommendations in at least two separate ways.

(1) It advocates, wherever practical, the expansion of existing mental hospital facilities to service community mental health needs. Mental hospitals are currently under the control and direction of the medical profession. This proposal would extend that control into yet other areas; and

(2) It advocates staffing patterns and responsibilities which in effect would make the other professions ancillary to and the handmaidens of medicine. The social worker, the psychiatric nurse and the psychologist could not make their optimal contribution within an atmosphere which would deprive each of professional independence. The NIMH regulations, then, while civic-minded in intent, would serve to extend the interests of medicine at the expense both of the interests of the other mental health professions, and even more importantly, at the expense of the public.

H.R. 2985, now before the Congress, would provide funds for the financing of community mental health centers. Congress thus has an opportunity to reassert

the spirit of the Joint Commission report. We hope that the final form of the bill will make it clear that (1) communities are to be encouraged to experiment with new patterns of mental health care, that many knowledgeable professional persons are seriously reevaluating the usefulness of the mental hospital itself and that a variety of outpatient settings could be the bases for the establishment of community mental health centers; and (2) personnel in public mental health programs, particularly community mental health centers, which are supported in part or wholly by Federal funds, should be selected on the basis of experience, training, and competence rather than on the basis of identity as a member of a particular profession, whether being appointed to staff, administrative, policy-determining or clinical positions, and it should be specifically recognized that some members of each of the core mental health professions (psychiatric nursing, social work, psychology and psychiatry) have the competence required in any such positions or roles.

Respectfully,

HERMAN FEIFEL, PH. D.,
President, and the Board of Directors.

DENVER, COLO., March 2, 1965.

HON. BYRON ROGERS,
*House Office Building,
Washington, D.C.:*

Wish to express deep concern over possible difficulty in securing passage of H.R. 2985 providing financial aid to States for operating community mental health centers. In view of heavy funding demands of growing Colorado mental health program I have strong doubts about our capacity to proceed with mental health center construction without assurance of Federal help in financing operating as well as construction costs. Am counting on your support of this essential legislation. I shall appreciate your making my position known at Tuesday committee hearing.

MRS. E. RAY CAMPBELL.

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, INC.,
Baltimore, Md., March 1965.

HON. OREN HARRIS,
*Chairman, House Interstate and Foreign Commerce Committee,
House of Representatives, House Office Building, Washington, D.C.*

MY DEAR SIR: The members of the Group for the Advancement of Psychiatry, who are also members of the American Psychiatric Association, strongly approve the passage of H.R. 2985, because from our point of view the provision for temporary financing for professional and technical staffs is a sine qua non for initiating the development of community mental health centers.

We are grateful to Senator Lister Hill for having introduced S. 513, and to you for having introduced H.R. 2985. We sincerely hope that the Congress will act favorably on this proposed legislation.

We are in complete agreement with the professional judgment of the American Psychiatric Association regarding this bill and with the testimony of Dr. Francis J. Braceland, who has also expressed our position with regard to the legislation you are proposing. We have avoided burdening you with a lengthy letter because the issue appears so clear.

As the president of the Group for the Advancement of Psychiatry, I wish to offer you my services in the event that they may be needed.

Sincerely,

LEO H. BARTEMEIR, M.D.,
President.

CLINIC ASSOCIATES MEDICAL GROUP,
Michigan City, Ind., March 16, 1965.

The undersigned, as members of the Clinic Associates Medical Group, a private association for group practice located in Michigan City, Ind., would like to make a statement in behalf of H.R. 2987, as introduced by Mr. Harris.

Physicians in the grass roots of medical practice, such as ourselves, have the responsibility of bringing to the people the benefits of the medical advances evolved

through the cooperative efforts of the National Institutes of Health, the medical schools and their affiliated hospitals and the regional centers of research. It is only by the application of these advances to individual cases that the patient benefits.

With the rocket-like speed of advancement of medical knowledge, even the most knowledgeable physician finds himself hard-pressed to keep abreast of one segment of the field of medicine. We feel that private group practice is the answer to this problem, affording the physician the freedom of interchange of ideas with coworkers, and yet maintaining a traditional patient-physician relationship.

There is one practical problem that interferes with the growth and development of private medical groups. They can only grow by gradual accretion, due to the difficulty of obtaining a long-term low-interest financing for their medical office building. So they build a building, within their budget, sufficient for today's practice. It is all they can afford in today's building money market. No sooner is it open than they need larger quarters. They wait a few years, and build a new wing, then another.

This is the time-honored method of growth for medical groups, adequate for another age. No longer can we afford this delay.

To be specific, our group is 15 years old in its present form. During this time, it has had three remodeling and one building program, as it increased in numbers from 4 doctors to the present 11. Now we are engaged in a new building program in an urban renewal area.

We can afford to build adequate quarters only for 13 to 16 physicians with our present borrowing capacity and repayment capability using traditional short-term mortgage loans. If we could get a long-term low-interest loan, we could build a much larger building on the same repayment schedule. This would enable us to build suites for 20 to 30 physicians, including representatives of all the medical specialties needed in this trading area of 75,000 persons. We could plan for 5 to 10 years ahead, instead of just for our most pressing needs.

The present bill would solve this problem for us very neatly. It would also help many other small groups, such as ourselves, all over the country who are furnishing personalized medical service to many millions of our fellow Americans. We are doing the best job we know how. But we want to do an even better job. This bill will help us greatly.

We support it, and respectfully urge that you consider it favorably—along with the other companion bills introduced by Mr. Harris—H.R. 2984, H.R. 2985, and H.R. 2986.

MILTON L. BANKOFF, M.D., *President.*
LEONARD G. PAUL, *Secretary.*

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 3, 1965.

HON. OREN HARRIS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am very happy to forward to you several communications from organizations and individuals in Connecticut in support of the bill H.R. 2985, which your committee now has under consideration.

The State of Connecticut is extremely interested in this legislation because of the assistance it would receive in obtaining professional help for its mental health centers.

May I direct your attention specifically to the letter of the Connecticut Association for Mental Health in which it is stated as follows: "We have always felt that the construction of mental health centers without matching grants for staffing would not provide adequate services for the mentally ill in the community." Adoption of this legislation is vital to the health and welfare of the people.

I wholeheartedly support this bill and urge your committee to act favorably on it.

Sincerely yours,

WILLIAM L. ST. ONGE,
Member of Congress.

P.S.—I would appreciate your inclusion of my letter with enclosures in the record of the hearings on this legislation.

W.L.S.

WOODSTOCK, CONN., *March 1, 1965.*

Representative WILLIAM ST. ONGE,
Room 1405, House Office Building,
Washington, D.C.:

Understand that you favorably endorse community mental health center bill H.R. 2985. Would you be so kind as to inform representative Oren Harris, chairman of the House Interstate and Foreign Commerce Committee of the extreme importance for staffing community mental health centers before the hearing of H.R. 2985, on March 4th.

LEIGH H. HAMMERSLEY,
Chairman, Quinebaug Valley Mental Health Planning Committee.

CONNECTICUT ASSOCIATION FOR MENTAL HEALTH, INC.,
New Haven, Conn., February 26, 1965.

HON. WILLIAM L. ST. ONGE,
1405 Longworth House Office Building,
Washington, D.C.

DEAR REPRESENTATIVE ST. ONGE: We understand that House bill 2985 for the initial staffing of community mental health centers will be heard before the Interstate and Foreign Commerce Committee on Thursday, March 4.

The Connecticut Association for Mental Health is vitally interested in the passage of this bill. We have always felt that the construction of mental health centers without matching grants for staffing would not provide adequate services for the mentally ill in the community.

We know that our 15 chapters throughout the State are also most interested in this important legislation. For instance, our Bridgeport chapter has over 30,000 names on a petition asking for the construction and staffing of a mental health center in the city of Bridgeport.

In the past, you have shown great concern for this legislation. We have several letters in our files indicating that you, personally, favor the bill and would work for its passage.

Would it be possible for you to speak to members of the Interstate and Foreign Commerce Committee (unfortunately there is no one from Connecticut on it) to try to convince them that the passage of this legislation will be important to the health and welfare of their constituents as well as to yours? Might it perhaps be possible for you to testify before the committee in favor of this bill?

Thank you very much for all the help that you have given us in the past.

Sincerely,

ROBERT E. BACON, *President.*

BROOKLYN, CONN., *March 1, 1965.*

HON. WILLIAM ST. ONGE,
House Office Building,
Washington, D.C.

DEAR MR. ST. ONGE: I understand that you have endorsed the community mental health center bill, House bill 2985.

May I request that you so inform Mr. Oren Harris, of Arkansas, chairman, House Interstate and Foreign Commerce Committee, before the hearing to be held on Thursday, March 4.

We in your district, who are establishing the Quinebaug Valley Health and Welfare Council, feel this bill is very important and as it might aid us in securing a staff.

Thank you for your endorsement.

Sincerely,

GLADYS P. JOHNSON.

STAMFORD, CONN., *March 1, 1965.*

HON. WILLIAM ST. ONGE,
House Office Building,
Washington, D.C.

DEAR SIR: Our organization urges you to speak to chairman Oren Harris and as many members of the committee as possible to support House bill 2985 which is coming up for a hearing before the Interstate and Foreign Commerce

Committee on March 4. This bill, as you know, provides for initial staffing of community mental health centers and is of vital importance to the welfare of all Connecticut communities. We have been informed that all Connecticut Representatives have already written to the Connecticut Association of Mental Health giving the bill their enthusiastic endorsement.

Thank you.

Sincerely,

ROGER J. STRASSER,
Chairman of the Legislative Committee of the Stamford-Darien Mental Health Association.

DANIELSON, CONN.

HON. WILLIAM L. ST. ONGE,
*House Office Building,
Washington, D.C.*

DEAR MR. ST. ONGE: I am writing to urge your further support of the community mental health center bill, House bill 2985. You are already on record as supporting this bill, with all other Connecticut Congressmen, for which I am very grateful. However, since the bill will be up for hearing before the House Interstate and Foreign Commerce Committee this next Thursday, March 4, I hope you will speak to Chairman Oren Harris and members of his committee, urging a favorable report of the bill.

You may have heard of the many activities of the recently organized Quinebaug Valley Health and Welfare Council. Originating in the Putnam area, this group has been active in researching and studying the mental health and general welfare needs of the 10 towns in northeastern Connecticut. The group represents a varied and responsible spectrum of 10-town citizens, including public school educators, physicians' groups, clergy of both Protestant and Roman Catholic denominations, womens' social service groups, and many others. The council's goal is to improve and reinforce the almost nonexistent services and facilities in this part of the State for troubled persons such as disturbed children, alcoholics, outpatients of mental hospitals, and those suffering from a variety of emotional illnesses. Our work is directly related to more efficient industrial production, antipoverty measures, and improved school and family life.

I feel that passage of House bill 2985 is of great importance to our work. Thank you for your consideration.

Very truly yours,

BARBARA B. COSTALES.

MIDDLETOWN, CONN., March 3, 1965.

Representative WILLIAM ST. ONGE,
Washington, D.C.:

Community mental health center bill, House bill 2984, has been called up at a hearing of the House Interstate and Foreign Commerce Committee, Thursday, March 4. All Connecticut Congressmen have endorsed this bill. Will you please reaffirm its importance to members of the committee?

Mrs. LANSING T. CARPENTER,
President, Connecticut Valley Mental Health Association.

AMERICAN PSYCHIATRIC ASSOCIATION,
Washington, D.C., February 26, 1965.

HON. OREN HARRIS,
*U.S. House of Representatives,
House Office Building,
Washington, D.C.*

DEAR CONGRESSMAN HARRIS: Last week here in Washington our association convened a meeting of nearly 500 citizens and professional people involved in State mental health planning. Delegates came from 45 States including your own. They represented well over 30,000 citizens now active in the State planning process made possible by appropriations by the Congress nearly 2 years ago. They reviewed progress, hopes for the future, and the realities that face them. A program is enclosed.

We shall have a report of this significant meeting ready within a month. Since, however, legislation is now pending before the Congress which bears so importantly

on the future of the national community mental health services program, I want to acquaint you immediately with the resolution that the conference passed by acclamation:

"Be it resolved that this conference (1) seconds President Johnson's recommendation to the Congress that Federal assistance be provided for the staffing of community mental health centers; (2) endorses Senate bill S. 513 and H.R. 2985, to implement the President's recommendation; and (3) urges that a coordinated and sustained effort be initiated by the American Psychiatric Association, aided by the National Association for Mental Health, and similarly dedicated groups and individuals to develop a national consensus of support so as to make possible the achievement of our common national goal of adequate community mental health services for all citizens."

There was, in a word, no question but that the delegates viewed the staffing problem as the greatest single impediment to progress and were as one in believing that the problem could be successfully dealt with only with the support proffered by these bills.

Sincerely yours,

WALTER E. BARTON, M.D.,
Medical Director.

CHILDREN'S AID AND FAMILY SERVICE, INC.,
Fitchburg, Mass., March 1, 1965.

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
*House Office Building,
Washington, D.C.*

GENTLEMEN: I am writing to urge your endorsement and vote on H.R. 2985 to enable grants for the initial cost of staff for Community Mental Health Centers authorized in 1963.

I support statement of Representative Harris who introduced this bill to the effect that sufficient qualified staff is the essential element in providing services for troubled people and urge that you vote in support of this.

Very truly yours,

Mary F. Shea,
Mrs. TIMOTHY J. SHEA, ACSW,
Executive Director.

Congressman OREN HARRIS,
House of Representatives, Washington, D.C.

PINE BLUFF, ARK., *March 5, 1965.*

DEAR SIR: I am writing to ask you to support H.R. 2985, on which I understand you committee is now conducting hearings. As a professional social worker, and as a citizen interested in the wider availability of mental health facilities, I feel that providing funds to staff community mental health agencies is at least as important as providing money for construction. Last year's Community Mental Health Centers Act was an excellent beginning, but if we are to provide comprehensive mental health services we must provide funds for staffing as well.

We hope that you and the members of your committee will support President Johnson's recommendation of a \$50 million appropriation for this purpose.

Sincerely yours,

MOODY C. BRYLES, ACSW.

Re H.R. 2985.

BALTIMORE, MD., *March 3, 1965.*

Congressman OREN HARRIS,
*Chairman, House Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.*

DEAR CONGRESSMAN HARRIS: I would like to urgently request your support of the above bill which applies to the staffing of community mental health centers. I am sure you are well acquainted with this legislation and only wish to point out to you what I feel is the necessity for such legislation in order to assist the community mental health program in its development. The States are obviously not in the position of carrying out the expensive, adequate staffing of these centers.

right in the beginning and certainly need the assistance of the Federal Government on a temporary basis, as is outlined in this legislation.

I hope, following the current committee hearings, that your committee will be able to favorably report this bill.

Sincerely yours,

JONAS R. RAPPEPORT, M.D.,

Chairman, Committee on Emotional Health, Medical-Chirurgical Faculty of Maryland, President-elect, Maryland Psychiatric Society.

CLEVELAND, OHIO, March 5, 1965.

Congressman OREN HARRIS,

Chairman, House Interstate and Foreign Commerce Committee,

House Office Building, Washington, D.C.:

Re hearings on bill H.R. 2985 the Academy of Medicine of Cleveland submits the following position statement on community mental health planning.

Planning for community mental health has long been a serious concern of doctors of medicine. For over 100 years mental health care has involved the use of public and private facilities. We believe that all sectors of the population will be served best by continued and improving cooperation between all agencies concerned with the provision of treatment to mentally ill patients and help for their families.

Since World War II mental health care has become very much more effective. The duration of treatment has become drastically shortened and previously "hopeless" patients have a reasonable chance for significant improvement. Certain principles of good mental health care have become established as basic requirements for future mental health planning. These lessons have been learned thorough hard work and experience in intensive-care public facilities, medical schools, private psychiatric hospitals, psychiatric units of general hospitals, and the offices of practicing physicians.

The cardinal principle of good mental health care is that the patient must be treated as a whole person. Not only must his emotional problems and environmental stresses be understood, but also careful attention must be given to his physical health. The mentally ill patient must have available to him all the diagnostic and treatment resources of general medicine in the same way that sick or injured person is expected to receive the best care that modern medical practice can provide. For this reason we believe that future mental health facilities must be interrelated with good general medical facilities, supervised and directed by psychiatrists, with provisions for training and research.

The psychiatrist is the physician who is responsible, in cooperation with consultants, for the care of the mentally ill patient. He must ultimately decide when the patient needs care in the hospital and when he can be treated as an outpatient. He must prescribe the medication for the patient, adjust the type and amount and be alert for untoward side effects. He must decide when the patient is ready to return to his home and his job. For these reasons we believe that psychiatrists have an inescapable obligation to continue to be very active in planning for mental health care.

Good mental health care is costly. Experience has shown that the best results are obtained where the patient load of the treatment personnel is low enough so that each patient can receive adequate time and attention. Experience shows that intensive care if applied early is often more economical in returning the patient to a useful place in the community rather than requiring long-term care in a chronic hospital.

How can the individual patient afford such costly care? Obviously there must be some way to plan ahead for such expenses and somehow the expense must be shared by large groups all sharing the same risks. Voluntary prepayment through health insurance has been much more successful in doing this job than was ever anticipated at the end of World War II. The spread of health insurance has placed private hospital psychiatric care within the reach of millions of people who could not otherwise afford it. The insurance programs in this community have led the Nation in providing this kind of coverage. In Ohio half of the admissions to mental hospitals are in private facilities with an average stay of less than 24 days. Furthermore, the trend to coverage of mental illness in health insurance is accelerating rapidly. Average length of stay in the hospital is still decreasing.

We recognize, however, that in spite of the impressive success of health insurance there remains a sector of the population without adequate provision for good

mental care. The departments of mental hygiene of the various States are making an effort to provide intensive care but budget limitations make optimum care unobtainable to some social groups and some geographical areas.

We believe that the Community Mental Health Center Act (Public Law 88-164) as passed by Congress in 1963 holds promise for delivering much better mental health care to these groups handicapped either by their financial position or by their geographical location. To implement this act, we believe that transitional support would be necessary to effect the change from total Government to a multiple-shared financing program. We believe that it is possible to provide maximum initial support and decreasing increments until other financial arrangements make it possible to carry the load within the local community.

Staffing community mental health centers should follow the pattern those agencies now in operation which have been successful in dealing with mental health problems. Provision should be made for the participation of clinical psychologists, psychiatric social workers, psychiatric nurses, occupational therapists and other related professionals all working together for the benefit of the patient under the supervision of the psychiatrist.

MIDDLETON H. LAMBRIGHT, M.D.,
*President, Academy of Medicine of Cleveland,
 Cuyahoga County Medical Society.*

MICHIGAN SOCIETY FOR MENTAL HEALTH, INC.,
Detroit, Mich., March 8, 1965.

Congressman JAMES HARVEY,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARVEY: Thank you for visiting with the society's committee of the board in Washington on March 4. We are pleased to respond to your request to the Michigan Society for Mental Health for our statement and suggested amendment to H.R. 2985 which is before your committee at this time.

As the bill is presently written the Federal subsidy for temporary and initial staffing would apply only to those new facilities provided the States under Public Law 88-164 of 1963. We believe that such a restriction penalizes those States who may have already provided themselves with building facilities but who could through this measure initiate new, and enrich present programs of mental health services at the community level. In other words, the emphasis of the amendments we are suggesting in H.R. 2985 should be on beefing up the professional manpower to provide services to the mentally ill and retarded regardless of the vintage of the building—as long as they help meet the problem at the community level. Michigan has stopped building additional new beds for the mentally ill. This is, and has been for several years an accepted policy of the legislature, the Governor, and the department of mental health. The only capital construction anticipated in Michigan is for mentally ill children, replacement beds in State hospitals, and some small community based comprehensive service centers for the retarded.

Under our new Community Mental Health Services Act, Public Act 54, 1963, we are committed to expansion of services at the community level with joint State-local financing and local coordinated administration. As evidence of this, you should have these two pieces of information. (1) In about 14 months, 16 Michigan counties comprising 62 percent of the State's population have formally adopted Public Act 54 and are developing mental health services. In addition, six more of the larger counties have official formal study committees of the Board of Supervisors. When they formalize their action, which is anticipated this year, the State will within 2 years have more than 75 percent of its population served. (2) In another area; namely the development of psychiatric units in general hospitals, Michigan has more than 500 psychiatric beds in 19 community general hospitals. The significant and dramatic fact about this is that these 500-plus beds had more than 15,000 psychiatric admissions last year as compared with 7,500 admissions in 22,000 State hospital beds for the mentally ill.

The amendments, we therefore propose, would be of significant value to accelerating Michigan's Community Mental Health Services program. This same situation we might add would be similar in most of the larger States who have taken the initiative in the community mental health services movement. The attached bill H.R. 2985 contains our suggested amendments. Again, we appreciate the opportunity of calling this to your attention as a member of Congressman

Harris' committee and to our Michigan congressional delegation. Our officers and board are impressed by the attitude of Congress on mental health matters this year.

Cordially,

HAROLD G. WEBSTER,
Executive Director.

KANSAS ASSOCIATION FOR MENTAL HEALTH, INC.,
Topeka, Kans., March 4, 1965.

HON. CHESTER MIZE,
*House of Representatives,
Washington, D.C.*

DEAR MR. MIZE: Please convey to the House Interstate Commerce Committee our support of House Resolution 2985, and our hope for its passage.

As I stated when I visited your office recently in Washington, D.C., the Kansas Association for Mental Health has gone on record as favoring Federal matching funds for the staffing of community mental health centers.

It has taken 17 years of community organization work to gain the interest and tax support locally that enables the 21 existing community centers to provide psychiatric services to citizens in 49 of the State's 105 counties.

Most centers operate with less than full teams—a psychiatrist, a psychologist, a psychiatric social worker—and see no additional source of income from local strained tax levies. Federal matching funds would provide this relief.

In areas where centers still are in the planning stage, commissioners look to possible outside sources—such as Federal matching funds—before taking action that would increase the tax burden even further, and unnecessarily, should there be Federal matching funds.

Thank you for conveying our interest in passage of this legislation to Representative Oren Harris and his committee.

Sincerely yours,

MARION J. CRANEY.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS,
Chicago, Ill., March 2, 1965.

Re: H.R. 2985.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives of the United States,
Washington, D.C.*

DEAR REPRESENTATIVE HARRIS: As executive director of the National Society for Crippled Children and Adults, I am authorized by the executive committee of the board of trustees to express our endorsement of the proposed bill, H.R. 2985. The Community Health Services Extension Amendments of 1965 would permit continuation of grants to public or private nonprofit agencies for studies, experiments, and demonstrations leading to the development of new or improved methods of providing out-of-hospital services for chronically ill or aged persons.

The value of new approaches and new solutions in providing care and treatment to this segment of the population has been adequately justified by past performances of both public and voluntary agencies since the law was enacted in 1961.

We urge favorable consideration of this measure by your committee.

Sincerely,

SUMNER G. WHITTIER,
Executive Director.

UNIVERSITY OF MARYLAND,
SCHOOL OF MEDICINE,
Baltimore, Md., March 3, 1965.

Congressman OREN HARRIS,
*Chairman, House Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.*

DEAR SIR: The following letter is written with reference to that bill which allocates money to pay salaries to medical personnel in community mental health hospitals.

I write this letter to you as a nonpsychiatric physician and internist interested in the comprehensive care of patients. It is imperative that money be allocated to appropriately staff, with professionally trained personnel, those community psychiatric health structures which have already been sanctioned.

Custodial care of patients only repeats the relatively apathetic approach to total medical care that has obtained previously.

As a nonpsychiatric physician may I offer my plea to you to support the passage of that bill which will allocate funds for the staffing of the aforementioned hospitals.

Sincerely yours,

EPHRAIM T. LISANSKY, M.D.,
*Associate Professor of Medicine,
Chairman and Director of Committee on Postgraduate Courses.*

THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS,
Dover, Del., March 3, 1965.

HON. OREN HARRIS,
*Chairman of the Committee for Interstate and Foreign Commerce, U.S. House of
Representatives, House Office Building, Washington, D.C.*

MY DEAR SIR: This association has favored the expanding of health research throughout the country. We would like to add our approval of those provisions of H.R. 2984 (health research facilities construction act amendments) which would extend for 5 years the presently authorized activities of this act. In addition we believe that the provisions which would authorize public health service activity in the construction and operation of specialized regional or national research facilities, financed by Federal funds, will prove valuable in promoting more adequate research in the field of health.

Intensive research in proper facilities is essential to provide more rapid solution to those problems which are now confronting us in the establishment of better health services for all Americans. It is respectfully requested that favorable consideration be given to the provisions above mentioned in H.R. 2984, and that this letter be made a part of the record.

Respectfully yours,

FLOYD I. HUDSON, M.D., *President.*

THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS,
Dover, Del., March 8, 1965.

HON. OREN HARRIS,
*Chairman of the Committee for Interstate and Foreign Commerce, U.S. House of
Representatives, House Office Building, Washington, D.C.*

MY DEAR SIR: This association would like to express approval of the provisions of H.R. 2986. We are interested in the extension of the Vaccine Assistance Act for a 5-year period with the added provision that measles vaccine is included to provide overall important procedures which will minimize morbidity and mortality from this disease in future years. Included also is the extension of the Migrant Health Act which we feel is essential in those States where domestic migratory labor has contributed many health problems in past years. These problems are now on the road to correction and need further Federal assistance.

The general health grant authority has been of concern to us over the past few years. The association has established a task force, directed by Dr. Malcolm H. Merrill, health officer of California, which is currently working with a group from the U.S. Public Health Service to determine what should be done about this in the future. It is our opinion that extension of the general health grants for a period of 1 year will enable us to complete the study which will be available to you and your committee for guidance in the future. It is respectfully requested that you and the members of your committee give favorable consideration to H.R. 2986 as now written and that this letter be made a part of the record.

Respectfully yours,

FLOYD I. HUDSON, M.D., *President.*

AMERICAN ASSOCIATION OF DENTAL SCHOOLS,
Chicago, Ill., March 5, 1965.

Congressman OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce, House of Representatives,
Washington, D.C.*

DEAR CONGRESSMAN HARRIS: We have been informed that your committee is holding public hearings this week on several legislative proposals related to health, including H.R. 2984, a bill to extend health research facilities construction grants and to provide a broader base of support for this important health program. In behalf of the American Association of Dental Schools, I would like to record strong support for extension of this provision of the Public Health Service Act.

Since the establishment of the health research facilities construction program in 1956, both the quality and capacity of dental research establishments have been improved appreciably. As has undoubtedly been pointed out to the committee, however, the need for expansion and improvement of dental research facilities remains substantial if we are to achieve continued progress in solving the problems related to the most prevalent chronic disease which afflicts our people. It is, in our judgment, in the interest of national health not only to extend the health research facilities construction program but to increase the authorization in the appropriation to at least the \$80 million a year proposed in H.R. 2984.

It should be noted that the enactment and implementation of the Health Professions Educational Assistance Act of 1963 has created a special need for extension and expansion of the health research facilities construction program. As of January 1965, for example, 9 schools of dentistry had received funds for the construction of new or expanded educational facilities and at least 12 additional applications from dental schools are in development at the present time. It is of utmost importance that the planning and construction of these new and expanded educational facilities include provision for adequate and progressive research facilities. Without extension and a substantial increase in support of the health research facilities program, it appears likely that the planning of tomorrow's dental educational institutions will not incorporate the kind of research facilities which will be needed.

It is a historical fact that financial support available to dental schools for the construction and equipping of facilities simply has not been available in amounts needed to undertake the development of broadly based centers of research. As helpful as existing Federal support has been, there have been many instances in which dental schools presently involved in strong research programs have been unable to expand their activities in clearly desirable areas because of the lack of funds needed to match Federal assistance. In considering this problem in March of last year, the Executive Council of the American Association of Dental Schools adopted an action urging the appropriate committees of the Congress to support an increase in appropriations for the health research facilities program and strongly encouraged the allocation of a part of these funds for construction on a nonmatching basis.

For several years, dental educators and administrators have been concerned with the need to develop additional research centers or complexes patterned somewhat along the lines of the intramural program which is conducted by the National Institute of Dental Research. This concept was supported by Dr. James A. Shannon, Director of the National Institutes of Health, before the Committee on Appropriations of the House of Representatives in 1964 when he said: It is my personal conviction * * * that it is this type of approach that will break the mold of the past, broaden research in the dental sciences and provide adequate training spots for true scientists within the profession. I think this approach would have a profound impact on dental research activities in as little as 5 years."

The American Association of Dental Schools concurs fully with the desirability of such regional centers and, therefore, earnestly requests the committee to support that section of H.R. 2984 which would authorize the construction and operation of specialized regional or national research facilities.

We would also like to record the association's support for that provision of H.R. 2984 which would elevate the position of Special Assistant to the Secretary (Health and Medical Affairs) to the status of Assistant Secretary of the Department of Health, Education, and Welfare.

We will be pleased to provide any additional information regarding research activities of the dental schools of the United States which might be of assistance to your committee in the consideration of this important legislation.

May I respectfully request that this communication of support for H.R. 2984 be made a part of the record of the hearing on this legislation.

Respectfully yours,

REGINALD SULLENS, *Secretary.*

UNIVERSITY OF MARYLAND,
SCHOOL OF MEDICINE,
THE PSYCHIATRIC INSTITUTE,
Baltimore, Md., March 4, 1965.

Congressman OREN HARRIS,
Chairman, House Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.

DEAR SIR: I understand that House bill No. 2985 will soon be coming up for hearing. This bill is designed to provide funds for personnel to staff community mental health centers. This essential provision for personnel was cut out of the original National Mental Health Act. I am sure you will agree that a community mental health program cannot be built of bricks and mortar alone. Only Federal support can offer help by providing for adequate staffing of these centers.

I urge you to make every effort to assure the passage of this bill.

Sincerely,

GERALD D. KLEE, M.D.,
Associate Professor of Psychiatry.

AMERICAN PODIATRY ASSOCIATION,
Washington, D.C., March 12, 1965.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. HARRIS: The American Podiatry Association is very much interested in the provisions of H.R. 2984, H.R. 2986, and H.R. 2987 which are being considered by the Committee on Interstate and Foreign Commerce.

These three proposals are supported by our association in view of the contributions which their programs can make to the health of the people of this country.

H.R. 2984 is an essential followup to the passage of the Health Professions Educational Assistance Act of 1963. The construction of health research facilities is an integral part of the expansion programs of colleges of podiatry. These facilities are needed for necessary research and to attract qualified new faculty members.

H.R. 2986 among other important provisions would extend the special project grants for community health services, and it is this portion of the bill which is of special interest to us. A study in Philadelphia supported by this program appropriately called keep them walking, has revealed during the past 3 years new information about foot conditions in the aged and chronically ill. New and improved methods of keeping these people ambulatory through helath information and podiatric care programs have been developed and a number of chronic diseases have been detected. Additional programs in other sections are benefiting from the results of this study and community foot health programs are being established to assist older people lead productive lives for many more years.

H.R. 2987 to insure mortgages secured for financing construction costs of group practice facilities would assist with the better distribution of podiatrists and make more effective use of all available health personnel. Many small communities in the country are in need of the services of podiatrists, according to a recent manpower study, and the provisions of this bill would encourage recent graduates to consider settling in these places.

I appreciate the opportunity of presenting the views of the American Podiatry Association on these three measures.

Respectfully submitted.

SEWARD P. NYMAN, D.S.C.,
Executive Director.

(Whereupon, at 3:45 p.m., the committee was recessed subject to call.)

LEGISLATIVE HISTORY

Public Law 89-109
S. 510

TABLE OF CONTENTS

Index and summary of S. 5101
Digest of Public Law 89-1092

INDEX AND SUMMARY OF S. 510

Jan. 15, 1965	Sen. Hill introduced S. 510 which was referred to Senate Labor and Public Welfare Committee. Print of bill as introduced.
Jan. 18, 1965	Rep. Harris introduced H. R. 2986 which was referred to House Interstate and Foreign Commerce Committee. Print of bill as introduced.
Mar. 2, 1965	Senate subcommittee approved proposed amendment to S. 510.
Mar. 5, 1965	Senate committee voted to report S. 510.
Mar. 10, 1965	Senate committee reported S. 510 with amendments. S. Report No. 117. Print of bill and report.
Mar. 11, 1965	Senate passed S. 510 as reported.
Mar. 15, 1965	S. 510 was referred to House Interstate and Foreign Commerce Committee. Print of bill as referred.
Apr. 15, 1965	House committee reported H. R. 2986 with amendments. H. Report No. 249. Print of bill and report.
Apr. 28, 1965	House Rules Committee reported resolution for consideration of H. R. 2986. H. Res. 357, H. Report No. 268. Print of resolution and report.
May 3, 1965	House passed S. 510, substituting language of H. R. 2986. House conferees were appointed. H. R. 2986 tabled due to passage of S. 510.
July 19, 1965	Senate conferees were appointed.
July 23, 1965	House received conference report on S. 510. H. Report No. 676. Print of report.
July 26, 1965	Senate received and agreed to conference report.
July 27, 1965	House agreed to conference report.
Aug. 5, 1965	Approved: Public Law 89-109.

Hearing: H. committee on H. R. 2984, etc.

DIGEST OF PUBLIC LAW 89-109

COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965.

Extends and amends certain expiring provisions of the Public Health Service Act. Extends through June 30, 1968 the provisions relating to grants for intensive vaccination programs and to grants for family health service clinics for domestic agricultural migratory workers. Adds necessary hospital care for migratory workers to the scope of services which can be given migrant health grant support. Extends through June 30, 1967 the general public health services and special project grants for community health services.

89TH CONGRESS
1ST SESSION

S. 510

IN THE SENATE OF THE UNITED STATES

JANUARY 15, 1965

Mr. HILL introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Community Health
4 Services Extension Amendments of 1965".

5 IMMUNIZATION PROGRAMS

6 SEC. 2. (a) The first sentence of subsection (a) of
7 section 317 of the Public Health Service Act is amended
8 by striking out "and" before "\$11,000,000" and by inserting
9 "and such sums as may be necessary for each of the next
10 five fiscal years" immediately after "June 30, 1965,". The

1 second sentence of such subsection is amended by striking
2 out "the fiscal years ending June 30, 1963, and June 30,
3 1964" and inserting in lieu thereof "any fiscal year ending
4 prior to July 1, 1970". The third sentence of such sub-
5 section is amended by striking "and tetanus" and inserting
6 in lieu thereof "tetanus, and measles", and by striking out
7 "under the age of five years" and inserting in lieu thereof
8 "of preschool age".

9 (b) Subsection (a) of such section is further amended
10 by adding at the end thereof the following new sentence:
11 "Such grants may also be used to pay similar costs in connec-
12 tion with immunization programs against any other disease
13 of an infectious nature which the Surgeon General finds
14 represents a major public health problem in terms of high
15 mortality, morbidity, disability, or epidemic potential and to
16 be susceptible of practical elimination as a public health prob-
17 lem through immunization with vaccines or other preventive
18 agents which may become available in the future."

19 (c) Subsection (b) of such section is amended by strik-
20 ing out "of limited duration", by striking out "against polio-
21 myelitis, diphtheria, whooping cough, and tetanus" and
22 inserting in lieu thereof "against the diseases referred to in
23 subsection (a)", and by striking out "who are under the age
24 of five years" and inserting in lieu thereof "of preschool
25 age".

1 (d) Such section is further amended by striking out
2 “intensive community vaccination” wherever it appears in
3 subsections (a), (b), and (c) and inserting in lieu thereof
4 “immunization”.

5 MIGRATORY WORKERS HEALTH SERVICES

6 SEC. 3. Section 310 of the Public Health Service Act is
7 amended by striking out “the fiscal year ending June 30,
8 1963, the fiscal year ending June 30, 1964, and the fiscal
9 year ending June 30, 1965” and inserting in lieu thereof
10 “each fiscal year ending prior to July 1, 1970”, and by strik-
11 ing out “any year” and inserting in lieu thereof “any year
12 ending prior to July 1, 1965”.

13 GENERAL PUBLIC HEALTH SERVICES

14 SEC. 4. The first sentence of subsection (c) of section
15 314 of such Act is amended by striking out “first five fiscal
16 years ending after June 30, 1961” and inserting in lieu
17 thereof “first six fiscal years ending after June 30, 1961”.

18 SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH
19 SERVICES

20 SEC. 5. The first sentence of subsection (a) of section
21 316 of such Act is amended by striking out “first five fiscal
22 years ending after June 30, 1961” and inserting in lieu
23 thereof “first six fiscal years ending after June 30, 1961”.

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

By Mr. HILL

JANUARY 15, 1965

Read twice and referred to the Committee on Labor and Public Welfare

89TH CONGRESS
1ST SESSION

H. R. 2986

IN THE HOUSE OF REPRESENTATIVES

JANUARY 18, 1965

Mr. HARRIS introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Community Health
4 Services Extension Amendments of 1965".

5 IMMUNIZATION PROGRAMS

6 SEC. 2. (a) The first sentence of subsection (a) of
7 section 317 of the Public Health Service Act is amended by
8 striking out "and" before "\$11,000,000" and by inserting
9 "and such sums as may be necessary for each of the next
10 five fiscal years" immediately after "June 30, 1965,". The

1 second sentence of such subsection is amended by striking
2 out “the fiscal years ending June 30, 1963, and June 30,
3 1964” and inserting in lieu thereof “any fiscal year ending
4 prior to July 1, 1970”. The third sentence of such sub-
5 section is amended by striking “and tetanus” and inserting
6 in lieu thereof “tetanus, and measles”, and by striking out
7 “under the age of five years” and inserting in lieu thereof
8 “of preschool age”.

9 (b) Subsection (a) of such section is further amended
10 by adding at the end thereof the following new sentence:
11 “Such grants may also be used to pay similar costs in con-
12 nection with immunization programs against any other dis-
13 ease of an infectious nature which the Surgeon General finds
14 represents a major public health problem in terms of high
15 mortality, morbidity, disability, or epidemic potential and
16 to be susceptible of practical elimination as a public health
17 problem through immunization with vaccines or other pre-
18 ventive agents which may become available in the future.”

19 (c) Subsection (b) of such section is amended by
20 striking out “of limited duration”, by striking out “against
21 poliomyelitis, diphtheria, whooping cough, and tetanus” and
22 inserting in lieu thereof “against the diseases referred to in
23 subsection (a)”, and by striking out “who are under the
24 age of five years” and inserting in lieu thereof “of preschool
25 age”.

1 (d) Such section is further amended by striking out
2 “intensive community vaccination” wherever it appears in
3 subsections (a), (b), and (c) and inserting in lieu thereof
4 “immunization”.

5 MIGRATORY WORKERS HEALTH SERVICES

6 SEC. 3. Section 310 of the Public Health Service Act
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8 1963, the fiscal year ending June 30, 1964, and the fiscal
9 year ending June 30, 1965” and inserting in lieu thereof
10 “each fiscal year ending prior to July 1, 1970”, and by strik-
11 ing out “any year” and inserting in lieu thereof “any year
12 ending prior to July 1, 1965”.

13 GENERAL PUBLIC HEALTH SERVICES

14 SEC. 4. The first sentence of subsection (c) of section
15 314 of such Act is amended by striking out “first five fiscal
16 years ending after June 30, 1961” and inserting in lieu
17 thereof “first six fiscal years ending after June 30, 1961”.

18 SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH
19 SERVICES

20 SEC. 5. The first sentence of subsection (a) of section
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22 years ending after June 30, 1961” and inserting in lieu
23 thereof “first six fiscal years ending after June 30, 1961”.

89TH CONGRESS
1ST SESSION

H. R. 2986

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

By Mr. HARRIS

JANUARY 18, 1965

Referred to the Committee on Interstate and Foreign
Commerce

March 2, 1965

SENATE

9. MANPOWER. A subcommittee of the Labor and Public Welfare Committee voted to report to the full committee with amendments S. 974, to amend the Manpower Development and Training Act of 1962. p. D144
10. MIGRATORY HEALTH. A subcommittee of the Labor and Public Welfare Committee approved for full committee consideration an amendment to S. 510, proposed Community Health Services Extension Amendments. The "Daily Digest" states that "The amendment approved today would authorize appropriations under the Migrant Health Act of 1963 of \$7 million for fiscal year 1966; \$8 million for fiscal year 1967; \$9 million for fiscal year 1968; and \$10 million for fiscal year 1969, and the years thereafter." p. D144
11. NOMINATION. The Post Office and Civil Service Committee approved the nomination of John W. Macy, Jr., for reappointment as a Civil Service Commissioner. p. D144

ITEMS IN APPENDIX

12. FARM LABOR. Extension of remarks of Rep. Todd expressing concern over the lack of farm laborers in Michigan due to the termination of the Bracero program and inserting an East Rapids Chamber of Commerce resolution urging the reenactment of the "Bracero Labor Act". p. A908
13. WATER POLLUTION. Extension of remarks of Rep. McCarthy on the "serious water pollution problems in...Lake Erie" and inserting the text of a TV broadcast on this subject, "Danger in Every Drop." pp. A912-3
14. BUDGET; DEBT. Rep. Stalbaum inserted an editorial, "Different View of Federal Finances," which he stated gives "an enlightening thought to those who are concerned over our economy and...the Federal debt." p. A907-8

BILLS INTRODUCED

15. ANIMALS. H. R. 5647, by Rep. Cleveland, to provide for the humane treatment of vertebrate animals used in experiments and tests by recipients of grants from the United States and by agencies and instrumentalities of the U. S. Government; to Interstate and Foreign Commerce. Remarks of author pp. 3882-3
16. FARM LABOR. H. R. 5649, by Rep. Corman, to encourage the States to extend coverage under their State unemployment compensation laws to agricultural labor; to Ways and Means Committee.
17. TAXATION. H. R. 5652, by Rep. Curtis, to amend the Internal Revenue Code of 1954 to allow a farmer a deduction from gross income for water assessments levied by irrigation ditch companies; to Ways and Means Committee.
18. FOREIGN AID. H. R. 5657, by Rep. Gray, to promote the general welfare, foreign policy, and security of the United States; to Ways and Means Committee.
19. MONOPOLIES. H. R. 5667 by Rep. Lindsay, for the establishment of a Commission on Revision of the Antitrust Laws of the United States; to Judiciary Committee.

20. RESEARCH. H. R. 5638 by Rep. Aspinall, to authorize the Secretary of the Interior to employ aliens in a scientific or technical capacity; to Interior and Insular Affairs Committee.
H. R. 5654 by Rep. Fascell, to provide for expanded research in the oceans and the Great Lakes to establish a National Oceanographic Council; to Merchant Marine and Fisheries Committee.
21. RECLAMATION. H. R. 5666 by Rep. King, Utah, to amend the Small Reclamation Projects Act of 1956; to Interior and Insular Affairs Committee.
H. R. 5692 by Rep. Duncan, Oregon, to authorize the Secretary of the Interior to construct, operate, and maintain the Illinois Valley diversion, Rogue River Basin project, Oregon; to Interior and Insular Affairs Committee.
22. PATENTS. H. R. 5675 by Rep. Rodino, to amend section 1498 of title 28, United States Code, to authorize the use or manufacture, in certain cases, by or for the United States of any invention described in and covered by a patent of the United States; to Judiciary Committee.
H. R. 5680 by Rep. St. Onge, for the general revision of the copyright law, title 17 of the United States Code; to Judiciary Committee.
23. PERSONNEL. H. R. 5685 by Rep. Sikes, to amend the Civil Service Retirement Act to permit retirement with full annuity upon attainment of the age of 55 years and completion of 30 years of service, to liberalize the formula for computation of reduced annuity; to Post Office and Civil Service Committee.
H. R. 5694 by Rep. Horton, to amend the Civil Service Retirement Act to provide for the adjustment of inequities; to Post Office and Civil Service Committee. Remarks of author pp. 3881-2
H. R. 5695 by Rep. Horton, to amend the Civil Service Retirement Act, as amended, to provide for the recomputation of annuities of certain retired employees who elected reduced annuities at the time of retirement in order to provide survivor annuities for their spouses, and for the recomputation of survivor annuities for the surviving spouses of certain former employees who died in service or after retirement; to Post Office and Civil Service Committee.
24. POSTAL SERVICES. H. R. 5668 by Rep. Lindsay, to amend title 39, United States Code, to encourage the use by volume mailers of ZIP code through postage rate concessions; to Post Office and Civil Service Committee.
25. HAWAII. H. R. 5671 by Rep. Mink, to authorize the Secretary of the Interior to make a loan and grant to the State of Hawaii for the construction of the Kokee water project; Hawaii; to Interior and Insular Affairs Committee.
26. WOOL. H. R. 5690 by Rep. Burton, Utah, to extend the operation of the National Wool Act of 1954, as amended; to Agriculture Committee.
27. WEED CONTROL. H. R. 5696 by Rep. Long, Maryland, to provide for the control and progressive eradication of certain aquatic plants in the States of Maryland, Virginia, New Jersey, and Tennessee; to Public Works Committee.

March 5, 1965

12. ADJOURNED until Mon., Mar. 8, p. 4157

SENATE

13. MANPOWER. The Labor and Public Welfare Committee voted to report (but did not actually report) with amendment S. 974, to amend the Manpower Development and Training Act of 1962. p. D159

14. HEALTH. The Labor and Public Welfare Committee voted to report (but did not actually report) with amendment S. 510, to extend and amend certain expiring provisions of the Public Health Service Act relating to community health services. p. D159

15. COMMISSIONS; TECHNOLOGY. The Labor and Public Welfare Committee voted to report (but did not actually report) the nomination of Garth L. Mangum to be Executive Director of the National Commission on Technology, Automation, and Economic Progress. p. D159

ITEMS IN APPENDIX

16. LIVESTOCK. Rep. Nelsen inserted an address, "Livestock Industry: 1964", discussing problems of the industry and urging developing research and educational programs to promote the use of meat. p. A982

17. SOIL CONSERVATION. Extension of remarks of Rep. Dole expressing concern over the proposed reduction in appropriations for Soil Conservation Service programs, and inserting an editorial which "points up the importance of its uninterrupted progress." pp. A982-3

18. COTTON. Extension of remarks of Rep. Boggs criticizing the cotton program and stating that our present "Government programs for cotton have prevented us from increasing our commercial exports of cotton and have, as a result, denied us an important and sizeable contribution to the solution of our balance-of-payments problem." pp. A988-9

19. APPROPRIATIONS. Speech in the House by Rep. Evans paying tribute to the leadership of the House Appropriations Committee. pp. A989-90

20. RECLAMATION. Extension of remarks of Rep. Johnson, Calif., in support of legislation for the construction of the Auburn-Folsom south project and inserting the text of a paper showing the need for this project. pp. A977-8

21. POVERTY. Extension of remarks of Rep. Martin, Ala., inserting an editorial critical of the Appalachian program stating that aid should be given impoverished regions anywhere in the country--not just the Appalachian region. p. A991

Extension of remarks of Rep. Cohelan commending and inserting an address on "Rural Poverty and Rural Areas Development." pp. A994-6

22. RESEARCH. Extension of remarks of Rep. Findley inserting an article in support of Rep. Wilson's bill to establish a National Oceanographic Agency. pp. A990-1

23. WATER POLLUTION. Rep. McCarthy inserted a newspaper editorial on the need for a strong Federal program for water pollution control. p. A991

BILLS INTRODUCED

24. WEATHER. H. R. 5865 by Rep. Harris, to authorize the Secretary of Commerce to utilize funds received from State and local governments for special meteorological services; to Interstate and Foreign Commerce Committee.
25. TRANSPORTATION. H. R. 5875 by Rep. Mize, to amend section 1 (14)(a) of the Interstate Commerce Act to insure the adequacy of the national railroad freight car supply; to Interstate and Foreign Commerce Committee.
26. PEACE CORPS. H. R. 5876 by Rep. Morgan, to amend further the Peace Corps Act (75 Stat. 612), as amended, to Foreign Affairs Committee.
27. MONOPOLIES. H. R. 5877 by Rep. Morse, for the establishment of a Commission on Revision of Antitrust Laws of the United States; to Judiciary Committee.
28. FOREIGN AID. H. R. 5879 by Rep. Murphy, New York, to amend the Foreign Assistance Act of 1961 so as to provide for reductions in aid to countries in which property of the United States is damaged or destroyed by mob action; to Foreign Affairs Committee.
29. WOOL. H. R. 5882 by Rep. Poage, to extend the operation of the National Wool Act of 1954, as amended; to Agriculture Committee.
30. EDUCATION. H. R. 5890 by Rep. Steed, to authorize a 3-year program of grants for construction of veterinary medical education facilities, to Interstate and Foreign Commerce Committee.

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COMMITTEE HEARINGS MAR. 8:

Mineral exploration on certain national forest lands in Colo.; H. Interior (Payne, FS, to testify).
Proposed closing of certain USDA research facilities, S. Appropriations.

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Digest of CONGRESSIONAL PROCEEDINGS

OFFICE OF
BUDGET AND FINANCE

(For information only;
should not be quoted
or cited)

OF INTEREST TO THE DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

Washington, D. C. 20250

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SENATE

1. HEALTH. The Labor and Public Welfare Committee reported with amendments S. 510, to extend and amend exporing provisions of the Public Health Service Act relating to community health services (S. Rept. 117). p. 4452
2. PERSONNEL. Both Houses received from the President a report on the training of Federal employees in non-Government facilities during fiscal year 1964. pp. 4449, 4571

3. COTTON. Sen. Tower urged enactment of new cotton legislation and inserted a newspaper article, "Cotton Quandry: Present Federal Support Program Seems to Please No One." pp. 4478-9
Sen. Fannin criticized the reduction of acreage allotments for extra long staple cotton, stated that imports of such cotton from the United Arab Republic exceed 55,000 bales a year, and urged a review of the situation. pp. 4491-2
Sen. Eastland criticized the cotton proposal of the Committee for a Free Cotton Market, Inc., stating that the Committee proposed "to kill the present cotton program" and substitute the "old discredited and maligned Brannan plan which the Congress resoundly rejected 16 years ago." p. 4495
4. FARM PROGRAM. Sen. Talmadge proposed adoption of a new farm program which he stated should move away from all acreage controls and shift to domestic allotments based on pounds, bushels, bales, and other such measures, and should move away from Government price support loans and shift to direct, compensatory payments to farmers. pp. 4492-4
5. SOIL CONSERVATION; USER CHARGES. Sens. Carlson and McGovern criticized the proposed user charge on SCS technical assistance to farmers and ranchers and inserted items in support of their positions. pp. 4483, 4504-5
Received a Wash. Legislature resolution expressing opposition to the proposed SCS user charge on technical assistance. pp. 4450-1
6. PATENTS. Received from the Judiciary Committee a report, "Patents, Trademarks, and Copyrights" (S. Rept. 118). p. 4452
7. SOYBEANS. Sen. Hartke expressed concern over the recent authorization for the Continental Grain Co. to sell 3,357,000 bushels of soybeans to Russia, stating that Soybeans are in "tight supply" and the sale may cause an increase in domestic prices. p. 4507
8. DROUGHT. Sen. Carlson criticized a newspaper article stating that a new dust bowl was now forming on the High Plains of the Midwest and that the Government should discourage farming in the area. pp. 4481-3
9. REGIONAL DEVELOPMENT. Sen. Fulbright inserted and commended an Ark. Legislature resolution supporting enactment of legislation to establish an Ozarks Regional Development Commission. pp. 4503-4
10. BALANCE OF PAYMENTS. Sen. Proxmire inserted the testimony of AID Administrator Bell before the Senate Banking and Currency Committee on the balance of payments situation. pp. 4507-10
11. WATER RESOURCES. Sen. Moss stated that the Nation "is facing a water crisis," and urged an expanded water resources development program. pp. 4526-8
12. FARM LABOR. Sens. Randolph and Holland expressed concern as to whether there is a sufficient supply of domestic farm workers to harvest the fruit and citrus crops. pp. 4562-3
13. INTERGOVERNMENTAL RELATIONS. The Vice President appointed Sens. Ervin, Muskie, and Mundt as members of the Commission on Intergovernmental Relations. p. 4564

COMMUNITY HEALTH SERVICES EXTENSION AMEND-
MENTS OF 1965

MARCH 10, 1965.—Ordered to be printed

Mr. HILL, from the Committee on Labor and Public Welfare, submitted the following

REPORT

[To accompany S. 510]

The Committee on Labor and Public Welfare, to whom was referred the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill do pass.

SUMMARY

S. 510 would extend four existing grant-in-aid programs authorized by the Public Health Service Act, as amended, to provide assistance to the States and their communities in financing essential public health services. The legislation would continue:

The program of grants for immunizations against polio, diphtheria, whooping cough, and tetanus for the 5 fiscal years 1966-70 at an annual appropriation authorization of \$8 million, and add measles to the program;

The program of grants for migratory workers health services for 5 fiscal years with appropriation authorizations of \$7 million for 1966, \$8 million for 1967, \$9 million for 1968, and \$10 million each for 1969 and 1970;

The program of formula grants for general health services, mental health services, radiological health services, dental health services, health services for the chronically ill and aged, and schools of public health for 1 additional year, fiscal year 1967, with no change in the overall annual appropriation ceiling of \$50 million; and

The program of project grants to finance studies, experiments, and demonstrations for the development of new or improved methods of providing health services to the chronically ill or aged

persons for 1 additional year, fiscal year 1967, with no change in the \$10 million annual authorization for appropriations.

EXPLANATION

Grants for immunization programs

The conquest of poliomyelitis is one of the miracles of American medicine. Between 1954 and 1964 the number of cases of polio declined from 38,476 to 121 in this country. Of the 121 cases reported for 1964, a total of 94 were paralytic. We can all be proud of the curtailment of the deaths and crippling effects of poliomyelitis.

There can be no question regarding the contribution of the Vaccination Assistance Act of 1962 (Public Law 87-868) to the reduction of the incidence of polio. At the time of its enactment the Public Health Service estimated that only one-third of the children under 5 years of age had been immunized. Since its enactment in 1962 an estimated 58 million people have received 3 doses of oral polio vaccine and 7 million children have been immunized against diphtheria, tetanus, and whooping cough. By September 1964 some two-thirds of all children under 5 years of age had been immunized against poliomyelitis.

Between 1962 and 1964 the number of cases of polio was reduced from 910 to 121; diphtheria from 444 to 306; and tetanus from 322 to 271. (The 1964 figures for whooping cough are not yet available.)

It is the opinion of the committee that the progress in eliminating polio, diphtheria, tetanus, and whooping cough justifies the extension of the Vaccination Assistance Act for an additional 5 years (fiscal years 1966-70).

Under this legislation the Federal funds may be used only for the purchase of vaccines for preschool children, for the expenses of additional State and local personnel required for planning, organizing, and promoting immunization programs, and for additional epidemiologic and laboratory surveillance activities. All other expenses, including the cost of vaccines for individuals other than preschool children, must be borne by the States or their communities. Thus, the Federal share amounts to less than one-half of the total expense even when local medical, dental, and nursing associations and organizations contribute their services free of charge in the actual administration of the vaccines.

Since the enactment of the Vaccination Assistance Act of 1962 vaccines against measles have become available. Under S. 510, therefore, it is proposed to add measles as a disease that could be included in an immunization program. The latest figures (1962) show that measles accounted for 408 deaths as compared to 60 for polio, 83 for whooping cough, 215 for tetanus, and 41 for diphtheria. Each year some 4 million individuals are afflicted with measles; physicians estimate there is some residual brain damage in 1 out of every 1,000 cases of measles.

Although the major effort in immunizing against polio, diphtheria, whooping cough, and tetanus has been completed, there is still work to be done if the maximum level of protection is to be achieved. The main emphasis under the new authority of S. 510, however, would be in the area of immunization against measles.

Testimony was presented that current procedure under the community immunization program involves burdensome detailed record-

keeping with respect to the age of individuals vaccinated. Accordingly, the committee amendment to section 317 of the PHS Act authorizes the making of grants on the basis of estimates and eliminates the requirement of detailed recordkeeping as to age.

The committee recommends an authorization for appropriations of \$8 million for each of the 5 fiscal years 1966-70. This compares with \$14 million for fiscal year 1963, \$11 million for fiscal year 1964, and \$11 million for fiscal year 1965 under the provisions of the Vaccination Assistance Act of 1962. S. 510 as introduced authorized such sums as may be necessary for each of the 5 additional years.

Grants for migratory workers health services

In 1962, Public Law 87-692 was enacted to provide public health services for the estimated 1 million domestic agricultural migratory workers and their families. These individuals are essential to important segments of our farm economy but the seasonal nature of the work requires interstate travel that results in problems with respect to determining their legal residences.

During the 3 years that funds have been available under the authority of section 310 of the Public Health Service Act, project grants have been awarded to share in the cost of providing public health services in 100 counties. These services include immunizations, pre- and post-natal clinics, dental services, and case finding for such diseases as tuberculosis.

Information presented at the hearings showed that it would be desirable to extend the scope of the health services provided to include hospitalization in short-term hospitals. The cost of hospital care is expensive and those hospitals located in areas with heavy concentrations of migratory workers have great difficulty in meeting the expenses involved in providing emergency medical care to migrant workers whose incomes are very limited. In most cases the residence requirements of county welfare agencies prevent the use of funds that are available for the medical care of indigents who are permanent residents. The committee recommends, therefore, that hospital care be included among the health services financed with Federal assistance under the project grants for health services for migratory workers and their families under section 310 of the Public Health Service Act.

The fact that the bracero program has been terminated will increase the demand for additional domestic migratory farmworkers. This will increase the demand for health services under section 310 of the Public Health Service Act. The services presently provided are less extensive than those that were available to noncitizens under the bracero program under an international agreement. Then, too, the demand for funds will increase as more counties participate under the program. At present only 100 of the 1,000 counties with significant numbers of migratory health workers are receiving health services through the new program. The funds available for fiscal year 1965 for migrant workers health grants will not be enough to fund the approved applications on hand as of January 1, 1965.

In approving a 5-year extension in the program of project grants for health services for migratory workers and their families, the committee recommends appropriation authorizations of \$7 million for 1966, \$8 million for 1967, \$9 million for 1968, and \$10 million each for 1969 and 1970. S. 510 as introduced authorized such sums as may be necessary in each of the 5 years.

Formula grants under section 314(c)

Under the authority of section 314(c) of the Public Health Service Act, the Surgeon General awards formula grants on a matching basis to State and local health departments to assist in paying for the cost of programs in the fields of general health services, mental health services, radiological health services, health services for the chronically ill or aged, and dental public health services. In addition, formula grants are awarded to the 12 schools of public health that serve all of the State, city, and county health departments by training their professional public health workers.

Pending the completion of two major studies, the committee recommends the extension of the formula grants to States and local communities under section 314(c) for 1 additional year, through fiscal year 1967, and no change in the overall annual authorization of \$50 million for appropriations.

One of these major studies is being carried out by the Association of State and Territorial Health Officers. The committee looks forward to the recommendations of the association with respect to the grants-in-aid that are administered by the Public Health Service.

In addition, the 4-year study of the National Commission on Community Health Services will be completed within a year. This study to develop improved methods of providing community health services is under the direction of the well-qualified Mr. Marion Folsom. The sponsors are the American Public Health Association and the National Health Council.

In the case of the formula grants for schools of public health, however, the committee is of the opinion that to defer action would not be in the national interest. It is recommended, therefore, that the subceiling of \$2,500,000 earmarked for schools of public health under section 314(c) of the Public Health Service Act be raised to \$5 million with no increase in the overall appropriation authorization of \$50 million under such section.

The 12 schools of public health are a national resource. They serve as a source of professional public health personnel for all of the State and local governments and for all of the Federal agencies including the Public Health Service, the Department of Defense, and the Veterans' Administration.

The spokesman of the Association of Schools of Public Health testified at the hearing that more than 75 percent of the students at the school of public health operated by his State were not residents of the State.

The Second National Conference on Public Health Training, called at the direction of the Congress, convened during the summer of 1963 and recommended an expansion in the training of public health workers and an increase in the formula grants under section 314(c) to assist the schools of public health in expanding their training programs.

Last year the Congress approved the Graduate Public Health Training Amendments of 1964 that more than doubles the annual amount of Federal support for public health training. The resultant expansion in professional public health students requires additional support to the schools of public health if they are to maintain the high level of training that is now offered.

In the near future two new schools of public health will be established. Unless the formula grants are increased there will be a reduction in the amounts available to the 12 existing schools of public health.

The schools now in operation are located in—

Berkeley, Calif.	Minneapolis, Minn.
Los Angeles, Calif.	Chapel Hill, N.C.
New York, N. Y.	Pittsburgh, Pa.
Cambridge, Mass.	San Juan, P.R.
Baltimore, Md.	New Orleans, La.
Ann Arbor, Mich.	New Haven, Conn.

Project grants for community health services

The program of project grants for community health services were authorized by the Community Health Services and Facilities Act of 1961 (Public Law 87-395). These grants finance studies, experiments, and demonstrations for the development of improved methods of providing health services to the chronically ill or aged persons.

Since these project grants, as well as the formula grants under section 314(c), are being studied by the State and Territorial Health Officers Association and by the National Commission on Community Health Services, this committee recommends no change in the annual appropriation authorization of \$10 million and a 1-year extension until June 30, 1967.

THE COST

Public Health Service grants-in-aid	Authorization for appropriations in millions						
	Existing law		Proposed new authorizations (S. 510)				
	1965	1966	1966	1967	1968	1969	1970
Sec. 317 (immunizations).....	\$11	-----	\$8	\$8	\$8	\$8	\$8
Sec. 310 (migrants health).....	3	-----	7	8	9	10	10
Sec. 314(c) (formula grants).....	50	\$50	-----	50	-----	-----	-----
Sec. 316 (project grants).....	10	10	-----	10	-----	-----	-----
Total.....	74	60	15	76	17	18	18

AMENDMENTS

Section 2(a) of the bill was amended to specify an annual appropriation authorization of \$8 million for the immunization grants under section 317 of the Public Health Service Act. The bill as introduced authorized "such sums as may be necessary" for each of the 5 years of the extension. Existing law authorizes \$11 million in section 317 of the Public Health Service Act for fiscal year 1965.

Section 2(e) amends section 317 of the Public Health Service Act to authorize the making of grants for community immunization programs on the basis of estimates of the number of persons within the age groups eligible to receive such vaccines and to eliminate the requirement of detailed recordkeeping by grantees with respect to the age of individuals vaccinated.

Section 3 of the bill was amended to specify appropriation authorizations of \$7 million in 1966, \$8 million in 1967, \$9 million in 1968,

and \$10 million each for the years 1969 and 1970, to assist in financing health services for migratory workers. The bill as introduced authorized such sums as may be necessary in each of the 5 years of the extension. The increase in appropriation authorization is justified by the need to expand services in the 100 counties presently participating, to extend the program to some of the other 900 counties with significant numbers of migratory health workers, and to add hospitalization to the range of health services provided.

Section 3(b) was added to authorize necessary hospital care, primarily in emergency situations, as a health service to be financed through project grants under section 310 of the Public Health Service Act.

Section 4 of the bill was amended to increase the subceiling on appropriations under section 314(c) of the Public Health Service Act for formula grants to schools of public health from \$2,500,000 to \$5 million per year. This increase would help to offset the costs of the expanded numbers of students at schools of public health following the enactment of Public Law 88-497 (graduate public health training amendments) and would permit the new schools of public health now being established to participate in the program without a reduction in assistance to existing schools. The amendment would not increase the overall appropriation ceiling of \$50 million in section 314(c).

HEARINGS

The Subcommittee on Health conducted hearings on S. 510 on January 27, 1965. Representatives from the Department of Health, Education, and Welfare and its Public Health Service appeared and testified in favor of the legislation that is a part of the President's health program.

The enactment of the legislation was also urged by the Association of Schools of Public Health, the American Public Health Association, the State and Territorial Health Officers Association, the American Dental Association, the American Association of Dental Schools, and by interested individuals.

SECTION-BY-SECTION ANALYSIS OF S. 510

Section 1: This section of the bill provides that this legislation may be cited as the "Community Health Services Extension Amendments of 1965."

Section 2: Subsection (a), subsection 2, of the bill amends subsection (a) of section 317 of the Public Health Service Act to extend for 5 additional years the authority (which expires June 30, 1965) to make grants to States, and political subdivisions and instrumentalities approved by State health authorities, to pay the cost of vaccines for preschool children and administrative expenses of immunization programs against poliomyelitis, diphtheria, whooping cough, and tetanus; and the bill would make immunization programs against measles eligible for such assistance. The existing provisions authorize appropriations of \$14 million for fiscal year 1963, and \$11 million for each of the fiscal years 1964 and 1965. The bill would authorize appropriations of \$8 million for each of the next 5 fiscal years. As

under the existing provision, amounts appropriated for a fiscal year would be available for making grants during the fiscal year for which appropriated and the succeeding fiscal year. Under the bill, grants would cover the cost of purchasing vaccines needed to protect children "of preschool age," instead of "under the age of 5 years," as present law provides.

Section 2(b) of the bill adds to section 317(a) of the PHS Act authority to assist immunization programs against any other infectious disease which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future.

Section 2(c) of the bill amends subsection (b) of section 317 of the PHS Act by deleting the qualification that immunization programs be "of limited duration" and makes technical amendments to conform to changes made in subsection (a) of section 317.

Section 2(d) of the bill changes all references to "intensive community vaccination programs," in section 317 (a), (b), and (c), to "immunization programs."

Section 2(e) provides for grants on the basis of estimates and simplifies the reporting and recordkeeping requirements under the immunization program.

Section 3(a) extends for 5 additional years the authority of the Surgeon General (expiring June 30, 1965) under section 310 of the PHS Act to make grants to public and other nonprofit agencies, institutions, and organization for paying part of the cost of family health service clinics and special health projects for domestic agricultural migratory workers and their families. Appropriations of up to \$3 million were authorized for fiscal years 1963, 1964, and 1965, and the bill would authorize appropriations of \$7 million for fiscal year 1966, \$8 million for fiscal year 1967, \$9 million for fiscal year 1968, and \$10 million for each of the fiscal years 1969 and 1970.

Section 3(b) authorizes payment for necessary hospital care, primarily in emergency situations for migratory agricultural workers and their families.

Section 4(a): This section extends for 1 additional year section 314(c) of the PHS Act (expiring June 30, 1966), which authorizes annual appropriations of \$50 million to assist States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public health services, including demonstration and training grants and grants-in-aid to schools of public health.

Section 4(b) of the bill would increase the subceiling on appropriations for the formula grants for schools of public health from \$2,500,000 to \$5 million. This increase in the subceiling would not necessitate any increase in the overall appropriation authorization of \$50 million for section 314(c).

Section 5: This section extends for 1 additional year section 316 of the PHS Act (expiring June 30, 1966), which authorizes annual appropriations of \$10 million for grants to State or other public or nonprofit private agencies or organizations for studies, experiments, and demonstrations looking toward development of new or improved methods of providing community health services outside the hospital, particularly for chronically ill or aged persons.

CHANGES IN EXISTING LAW

In compliance with subsection (4) of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * *

GRANTS FOR FAMILY HEALTH SERVICE CLINICS FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

SEC. 310. There are hereby authorized to be appropriated [for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed \$3,000,000 for any year, as may be necessary] *not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, \$9,000,000 for the fiscal year ending June 30, 1968, and \$10,000,000 each for the fiscal years ending June 30, 1969, and June 30, 1970,* to enable the Surgeon General (1) to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishing and operating of such clinics, and (ii) special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, *including necessary hospital care, and* including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families.¹

PART B—FEDERAL COOPERATION

* * * * *

GRANTS AND SERVICES TO STATE

SEC. 314. (a) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention, treatment, and control of venereal diseases, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment, and control of such diseases, including the training of personnel for State and local health work, and to enable him to prevent

¹ Amendment to be effective with respect to appropriations for fiscal years beginning after June 30, 1965.

and control the spread of the venereal diseases in interstate traffic, and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to the venereal diseases, and to administer this section with respect to such diseases, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subsection.

(b) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention, treatment, and control of tuberculosis, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment, and control of such disease, including the provision of appropriate facilities for care and treatment and including the training of personnel for State and local health work, and to enable him to prevent and control the spread of tuberculosis in interstate traffic, and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to tuberculosis, and to administer this section with respect to such disease, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1945, the sum of \$10,000,000, and for each fiscal year thereafter a sum sufficient to carry out the purposes of this subsection.

(c) To enable the Surgeon General to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public health services, including grants for demonstrations and for training of personnel for State and local health work, there is authorized to be appropriated for each of the [first five fiscal years ending after June 30, 1961,] *first six fiscal years ending after June 30, 1961*, the sum of \$50,000,000. When so provided in any Act appropriating funds for carrying out the purposes of this subsection for any year, such amounts as may be specified in such Act shall be available only for allotments and payments for such services and activities included under this subsection as may be provided in such Act; and in such case the requirements of subsection (h) shall be separately applied to such allotments and payments. Of the sum appropriated for each fiscal year pursuant to this subsection there shall be available (1) such amount as may be necessary to enable the Surgeon General to provide demonstrations and to train personnel for State and local health work and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist States in carrying out the purposes of this subsection, and (2) an amount not to exceed [\$2,500,000] \$5,000,000 to enable the Surgeon General to make grants-in-aid, under such terms and conditions as may be prescribed by regulations, for provision in public or nonprofit schools of public health accredited by a body or bodies recognized by the Surgeon General, of comprehensive professional training, specialized consultative services, and technical assistance in the fields of public health and in the administration of State and local public health programs, except that in allocating funds made available under this clause (2) among such schools of public health the Surgeon General shall give primary consideration

to the number of federally sponsored students attending each such school.

(d) For each fiscal year, the Surgeon General, with the approval of the Secretary, shall determine the total sum from the appropriation under subsection (a), the total sum from the appropriation under subsection (b), and, within the limits specified in subsection (c), the total sum from the appropriation under that subsection which shall be available for allotment among the several States. He shall, in accordance with regulations, from time to time make allotments from such sums to the several States on the basis of (1) the population, (2) the extent of the venereal disease problem, the extent of the tuberculosis problem, and the extent of the mental health problem and other special health problems, respectively, and (3) the financial need of the respective States. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

(e) To enable the Surgeon General to carry out the purposes of part B of title IV and to assist, through grants, States, counties, health districts, and other political subdivisions of the State, and public and nonprofit agencies, institutions, and other organizations, in establishing and maintaining organized community programs of heart disease control, including grants for demonstrations and the training of personnel, there is hereby authorized to be appropriated for each fiscal year such sums as may be necessary for such purposes. For each fiscal year, the Surgeon General, with the approval of the Secretary, shall determine the total sum from the appropriation under this subsection which shall be available for allotment among the several States, and shall, in accordance with regulations, from time to time make allotments from such sum to the several States on the basis of (1) the population and (2) the financial need of the respective States. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

(f) The Surgeon General, with approval of the Secretary, shall from time to time determine the amounts to be paid to each State from the allotments to such State, and shall certify to the Secretary of the Treasury the amounts so determined, reduced or increased, as the case may be, by the amounts by which he finds that estimates of required expenditures with respect to any prior period were greater or less than the actual expenditures for such period: *Provided*, That in the case of amounts to be paid from allotments to any State under subsection (e), the Surgeon General may determine and certify to the Secretary of the Treasury amounts to be paid to a county health district, other political subdivision of the State or to any public or nonprofit agency, institution, or other organization in the State, if he finds that payment to such subdivision or other organization has been recommended by the State health authority of the State, and (1) that the State health authority has not, prior to August 1 of the fiscal year for which the allotment is made, presented and had approved a plan in accordance with subsection (g), or (2) that the State health authority is not authorized by law to make payments to such other organization. Upon receipt of such certification, the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay in accordance with such certification.

(g) The moneys so paid to any State, or to any political subdivision or other organization, shall be expended solely in carrying out the purposes specified in subsection (a), or subsection (b), or subsection (c), or subsection (e), as the case may be, and in accordance with plans, approved by the Surgeon General, which have been presented by the health authority of such State, or, under the circumstances specified in subsection (f)(1), by the political subdivision, or the agency, institution or other organization to whom the payment is made, and, to the extent that any such plan contains provisions relating to mental health, by the mental health authority of such State.

(h) Money so paid from allotments under subsections (a), (b), (c), and (e), shall be paid upon the condition that there shall be spent in such State for the same general purpose from funds of such State and its political subdivisions (or in the case of payments to a political subdivision or to an agency, institution or other organization under circumstances specified in subsection (f)(1), from funds of such political subdivision or organization), an amount determined in accordance with regulations.

(i) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of the State (or, in the case of payments to any political subdivision or any agency, institution, or other organization under the circumstances specified in subsection (f)(1), such subdivision or organization) finds that, with respect to money paid to the State, subdivision, or organization out of appropriations under subsection (a), or subsection (b), or subsection (c), or subsection (e), as the case may be, there is a failure to comply substantially with either—

- (1) the provisions of this section;
- (2) the plan submitted under subsection (g); or
- (3) the regulations;

the Surgeon General shall notify such State health authority or mental health authority, political subdivision, or organization that further payments will not be made to the State subdivision, or organization from appropriations under such subsection (or in his discretion that further payments will not be made to the State, subdivision, or organization from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be any such failure. Until he is so satisfied the Surgeon General shall make no further certification for payment to such State, subdivision, or organization from appropriations under such subsection, or shall limit payment to activities in which there is no such failure.

(j) All regulations and amendments thereto with respect to grants to States under this section shall be made after consultation with a conference of the State health authorities and, in the case of regulations or amendments which relate to or in any way affect grants under subsection (c) for work in the field of mental health, the State mental health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of any such regulations or amendments, of the State health authorities and, in the case of regulations or amendments which relate to or in any way affect grants under subsection (c) for work in the field of mental health, the State mental health authorities.

(k) Funds appropriated under subsection (a) and funds appropriated under subsection (b), in addition to being available for payments

to States, shall also be available for expenditure by the Surgeon General in ing expenditures for printing and binding of the findings of expenditures for printing and binding of the findings of investigations, and for pay and allowances and traveling expenses of personnel of the Service engaged in activities authorized by the respective subsections.

(l) Except as otherwise provided in this subsection the provisions of this section shall be applicable to Guam and American Samoa in the same manner in which they apply to the States. Amounts paid to Guam or American Samoa from its allotment under subsections (a), (b), (c), or (e) of this section, together with matching funds of Guam or American Samoa, respectively, may, with the approval of the Surgeon General, be expended in carrying out the purposes specified in any such subsection or subsections other than the one under which the allotment was made.

(m) The Surgeon General, at the request of the State health authority or, where appropriate, the State mental health authority, may reduce the payments to a State under this section by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Public Health Service to the State or any of its political subdivisions when such detail is made for the convenience of and at the request of the State and for purposes of carrying out its State plan approved under this section. The amount by which such payments are so reduced shall be available for payment of such costs by the Surgeon General, but shall, for purposes of subsection (h), be deemed to have been paid to the State.

* * * * *

SPECIAL PROJECT GRANTS FOR IMPROVING COMMUNITY HEALTH SERVICES

SEC. 316. (a) There are hereby authorized to be appropriated for each of the [first five fiscal years ending after June 30, 1961] *first six fiscal years ending after June 30, 1961*, the sum of \$10,000,000 for grants to State or other public or nonprofit private agencies or organizations for studies, experiments, and demonstrations looking toward development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons. Any grant for any such project made from an appropriation under this section for any fiscal year may include such amounts as the Surgeon General determines to be necessary for succeeding fiscal years for completion of the Federal participation in the project as approved by the Surgeon General.

(b) Payments under this section may be made in advance or by way of reimbursement, and in such installments, as may be determined by the Surgeon General; and shall be made on such conditions as the Surgeon General finds necessary to carry out the purposes of this section. Nothing in this Act shall preclude a State or community from establishing and collecting fees for personal health services which may be provided through programs financed from funds under this section when collection of such fees is authorized or required by State or local law.

(c) The Surgeon General, at the request of a State or other public agency, may reduce the grant to such agency under this section by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Public Health Service to such agency when such detail is made for the convenience of and at the request of such agency and for the purpose of carrying out its study, experiment, or demonstration with respect to which a grant is made under this section. The amount by which such grant is so reduced shall be available for payment of such costs by the Surgeon General, but shall, for purposes of subsection (b), be deemed to have been paid to such agency.

GRANTS FOR INTENSIVE VACCINATION PROGRAMS

SEC. 317. (a) There are hereby authorized to be appropriated \$14,000,000 for the fiscal year ending June 30, 1963, [and] \$11,000,000 each for the fiscal years ending June 30, 1964, and June 30, 1965, and \$8,000,000 *for each of the next five fiscal years*, to enable the Surgeon General to make grants to States and, with the approval of the State health authority, to political subdivisions or instrumentalities of the States under this section. Amounts appropriated pursuant to this section for [the fiscal years ending June 30, 1963, and June 30, 1964] *any fiscal year ending prior to July 1, 1970*, shall be available for making such grants during the fiscal year for which appropriated and the succeeding fiscal year. Such grants may be used to pay that portion of the cost of [intensive community vaccination] *immunization* programs against poliomyelitis, diphtheria, whooping cough, [and tetanus] *tetanus, and measles* which is reasonably attributable to (1) purchase of vaccines needed to protect children [under the age of five years] *of preschool age* and such additional groups of children as may be described in regulations of the Surgeon General upon his finding that they are not normally served by school vaccination programs and (2) salaries and related expenses of additional State and local health personnel needed for planning, organizational, and promotional activities in connection with such programs, including studies to determine the immunization needs of communities and the means of best meeting such needs, and personnel and related expenses needed to maintain additional epidemiologic and laboratory surveillance occasioned by such programs. *Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future.*

(b) For the purposes of this section an [“intensive community vaccination”] *“immunization program”* means a program [of limited duration] which is so designed and conducted as to achieve, with the cooperation of practicing physicians, official health agencies, voluntary organizations, and volunteers, the immunization [against poliomyelitis, diphtheria, whooping cough, and tetanus] *against the diseases referred to in subsection (a)*, over the period of the program of all, or practically all, susceptible persons in a community, particularly

children [who are under the age of five years,] *of preschool age*, and which includes plans and measures looking toward the strengthening of ongoing community programs for the immunization against such diseases of infants and for maintenance of immunity in the remainder of the population. Nothing in this section shall be construed to require any State or any political subdivision or instrumentality of a State to have an [intensive community vaccination] *immunization* program which would require any person who objects to immunization to be immunized or to have any child or ward of his immunized.

(c)(1) Payments under this section may be made in advance *on the basis of estimates* or by way of reimbursement (*with necessary adjustments on account of underpayments or overpayments*), in such installments, and on such terms and conditions as the Surgeon General finds necessary to carry out the purposes of this section, and the Surgeon General may, if the applicant State or other political subdivision or instrumentality so requests, purchase and furnish vaccines in lieu of making money grants for the purchase thereof. *Nothing in this section shall be construed to require, or authorize any requirement of, any grantee to maintain a detailed record or provide a detailed report with respect to the age of individuals vaccinated with vaccines financed in whole or part under this section so long as such grantee maintains such records and makes such reports as the Surgeon General may require of the number of individuals actually vaccinated with such vaccines and which the Surgeon General finds that such number does not exceed the number of children estimated by him from time to time to be within the age group or groups eligible under this section to receive such vaccines.*

(2) Each applicant under this section for a money grant for the purchase of vaccines, or for a grant of vaccines in lieu of a money grant, for use in connection with an [intensive community vaccination] *immunization* program shall, at the time it files its application with the Surgeon General, provide the Surgeon General with assurances satisfactory to him that it will, if it receives such a grant, furnish any physician, who practices in the area in which such program is to be carried out and makes application therefor to it, with such amounts of vaccines as are reasonably necessary in order to permit such physicians during the period of such program to immunize his patients who are in the group for whose immunization such grant of money or vaccines is made.

(3) Each applicant for a grant under this section for use in connection with an [intensive community vaccination] *immunization* program shall, at the time it files its application for such grant with the Surgeon General, provide the Surgeon General with assurances satisfactory to him that it will, if it receives such grant, furnish such other services and materials as may be necessary to carry out such program.

(d) The Surgeon General, at the request of a State or other public agency, may reduce the grant to such agency under this section by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Public Health Service to such agency when such detail is made for the convenience of and at the request of such agency and for the purpose of carrying out a function for which a grant is made under this section. The amount by which such grant is so reduced shall be available for

payment of such costs by the Surgeon General, but shall, for purposes of subsection (c), be deemed to have been paid to such agency.

(e) Nothing in this section shall limit or otherwise restrict the use of funds which are granted to a State or to a political subdivision of a State under title V of the Social Security Act, or other provisions of this Act, or other Federal law and which are available for the purchase of vaccine or for organizing, promoting, conducting, or participating in immunization programs, from being used for such purposes in connection with programs assisted through grants under this section.

* * * * *



89TH CONGRESS
1ST SESSION

[Report No. 117]

JANUARY 15, 1965

MARCH 10, 1965

Reported by Mr. HILL, with amendments

[Omit the part struck through and insert the part printed in *italic*]

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the “Community Health
4 Services Extension Amendments of 1965”.

5 IMMUNIZATION PROGRAMS

6 SEC. 2. (a) The first sentence of subsection (a) of
7 section 317 of the Public Health Service Act is amended
8 by striking out “and” before “\$11,000,000” and by inserting

1 “and ~~such sums as may be necessary~~ \$8,000,000 for each of
2 the next five fiscal years” immediately after “June 30,
3 1965,”. The second sentence of such subsection is amended
4 by striking out “the fiscal years ending June 30, 1963, and
5 June 30, 1964” and inserting in lieu thereof “any fiscal year
6 ending prior to July 1, 1970”. The third sentence of such
7 subsection is amended by striking “and tetanus” and insert-
8 ing in lieu thereof “tetanus, and measles”, and by striking
9 out “under the age of five years” and inserting in lieu thereof
10 “of preschool age”.

11 (b) Subsection (a) of such section is further amended
12 by adding at the end thereof the following new sentence:
13 “Such grants may also be used to pay similar costs in connec-
14 tion with immunization programs against any other disease
15 of an infectious nature which the Surgeon General finds
16 represents a major public health problem in terms of high
17 mortality, morbidity, disability, or epidemic potential and to
18 be susceptible of practical elimination as a public health prob-
19 lem through immunization with vaccines or other preventive
20 agents which may become available in the future.”

21 (c) Subsection (b) of such section is amended by strik-
22 ing out “of limited duration”, by striking out “against polio-
23 myelitis, diphtheria, whooping cough, and tetanus” and
24 inserting in lieu thereof “against the diseases referred to in

1 subsection (a)”, and by striking out “who are under the age
2 of five years” and inserting in lieu thereof “of preschool
3 age”.

4 (d) Such section is further amended by striking out
5 “intensive community vaccination” wherever it appears in
6 subsections (a), (b), and (c) and inserting in lieu thereof
7 “immunization”.

8 (e) Paragraph 1 of subsection (c) is amended by insert-
9 ing “on the basis of estimates” after “advance”; by striking
10 out the comma after the word “reimbursement” and inserting
11 in lieu thereof “(with necessary adjustments on account of
12 underpayments or overpayments),”; and by adding at the
13 end of such paragraph the following sentence: “Nothing in this
14 section shall be construed to require, or authorize any require-
15 ment of, any grantee to maintain a detailed record or provide
16 a detailed report with respect to the age of individuals vacci-
17 nated with vaccines financed in whole or part under this
18 section so long as such grantee maintains such records and
19 makes such reports as the Surgeon General may require of
20 the number of individuals actually vaccinated with such
21 vaccines and which the Surgeon General finds that such
22 number does not exceed the number of children estimated by
23 him from time to time to be within the age group or groups
24 eligible under this section to receive such vaccines.”

1 MIGRATORY WORKERS HEALTH SERVICES

2 SEC. 2. Section 310 of the Public Health Service Act is
3 amended by striking out “the fiscal year ending June 30,
4 1963, the fiscal year ending June 30, 1964, and the fiscal
5 year ending June 30, 1965” and inserting in lieu thereof
6 “each fiscal year ending prior to July 1, 1970”, and by strik-
7 ing out “any year” and inserting in lieu thereof “any year
8 ending prior to July 1, 1965”.

9 SEC. 3. (a) *Effective with respect to appropriations for*
10 *fiscal years beginning after June 30, 1965, section 310 of*
11 *the Public Health Service Act is amended by striking out “for*
12 *the fiscal year ending June 30, 1963, the fiscal year ending*
13 *June 30, 1964, and the fiscal year ending June 30, 1965,*
14 *such sums, not to exceed \$3,000,000 for any year, as may*
15 *be necessary” and inserting in lieu thereof “not to exceed*
16 *\$7,000,000 for the fiscal year ending June 30, 1966,*
17 *\$8,000,000 for the fiscal year ending June 30, 1967,*
18 *\$9,000,000 for the fiscal year ending June 30, 1968, and*
19 *\$10,000,000 each for the fiscal years ending June 30, 1969,*
20 *and June 30, 1970,”.*

21 (b) *Such section is further amended by inserting “in-*
22 *cluding necessary hospital care, and” immediately after “ag-*
23 *ricultural migratory workers and their families,” in clause*
24 *(1) (ii) of such section.*

GENERAL PUBLIC HEALTH SERVICES

SEC. 4. (a) The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

(b) *The third sentence of subsection (c) of section 314 of such Act is amended by striking out "\$2,500,000" and inserting in lieu thereof "\$5,000,000".*

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

89TH CONGRESS
1ST SESSION

S. 510

[Report No. 117]

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

By Mr. HULL

JANUARY 15, 1965
Read twice and referred to the Committee on Labor and Public Welfare

MARCH 10, 1965
Reported with amendments

Digest of CONGRESSIONAL PROCEEDINGS

OFFICE OF
BUDGET AND FINANCE

(For information only;
should not be quoted
or cited)

OF INTEREST TO THE DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

Washington, D. C. 20250

Official Business Postage and Fees paid
U. S. Department of Agriculture

Issued March 12, 1965

For actions of March 11, 1965

89th-1st; No. 46

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HIGHLIGHTS: Sen. Curtis criticized proposed cuts in ACP and SCS appropriations. Sen. McGovern stated discriminatory freight rates threaten Mid-West flour-milling industry. House received N. Dak. resolution opposing proposed reductions in SCS appropriations. Several Reps. introduced and discussed bills to restrict CCC sales of wheat. Rep. Ullman urged establishment of Resources and Conservation Council.

SENATE

1. HEALTH. Passed as reported S. 510, to extend and amend certain expiring provisions of the Public Health Service Act relating to community health services, including extension until June 30, 1970, of the authorization for grants to assist in financing health services for domestic migratory agricultural workers and their families. pp. 4711-14
2. MANPOWER. Unanimous consent was granted for the Labor and Public Welfare Committee to file its report on S. 974, to amend the Manpower Development and Training Act, during adjournment of the Senate this week end. p. 4707

3. APPROPRIATIONS. Sen. Curtis criticized proposed reductions in appropriations for the agricultural conservation program and for SCS technical assistance to farmers and ranchers, stated that the proposed cuts "threaten to undo much of the good work accomplished over the last 30 years." and inserted a county breakdown of funds expended in Nebr. for SCS technical assistance during fiscal year 1964. pp. 4741-2
 4. TRANSPORTATION. Sen. McGovern stated that "the establishment of discriminatory freight rates, disrupting the historical balance between wheat and flour shipping costs, is threatening the flour-milling industry in the Middle West by forcing millers to relocate plants near large centers of population and consumption," and inserted a S. Dak. Legislature resolution urging enactment of legislation "providing for fair and equitable regulation of all modes of commercial transportation." p. 4751
 5. POVERTY. Sen. Morse inserted a speech by Sen. McNamara to the National Committee for Community Development reviewing problems that may be encountered in administering the poverty program and suggesting ways in which the program should be implemented. pp. 4761-2
 6. FOREIGN CURRENCIES. Sen. Hayden inserted tabulations on the expenditure of foreign currencies by certain Senate committees for travel abroad. pp. 4698-4702
 7. FARM INCOME. Sen. Young, N. Dak., expressed concern over the level of farm income as compared with costs of operation and inserted a N. Dak. Legislature resolution urging adoption of "a system of price supports and production controls for agricultural commodities now covered by price supports that will assure adequate income for farmers and assure solvency for all of rural America." p. 4698
 8. FOREIGN TRADE. Sen. Carlson stated that the recent dock strike on the southern and east coasts had a direct and adverse effect on the agriculture and economy of Kan., particularly with regard to the export of wheat and flour. pp. 4707-8
 9. RADIOACTIVE FALLOUT. Sen. Gruening expressed concern over the possible adverse effects of radioactive fallout on human health and inserted an article, "Radioactive Fallout Threat to Eskimos." pp. 4750
 10. ECONOMIC REPORT. The "Daily Digest" states that the Joint Economic Committee "approved its report on the President's Economic Report. It was announced that this report would be filed in the House on Wednesday, March 17." p. D183
 11. ADJOURNED until Mon., Mar. 15. p. 4763
- HOUSE
12. APPROPRIATIONS. Rep. Albert inserted the Committee on Appropriations' schedule for reporting and for action on appropriation bills for this session. p. 4632
 13. ELECTRIFICATION. Rep. Rivers, Alaska, defended the proposed Rampart Dam project on Alaska's Yukon River against criticism in an editorial, "World's Biggest Boondoggle." p. 4269
 14. RESEARCH. Rep. Roush discussed the geographic distribution of the research and development fund. pp. 4649-50

of course, does not include any allowance for unforeseen contingencies, particularly in southeast Asia, and assumes that receipts from sales of U.S. military goods and services continue at a level above \$1 billion annually. It is clear, however, that, in terms of expenditures, any further substantial reductions could only be accomplished through a major realignment of our force structure overseas.

As a part of this intensified effort we are reviewing certain of our planned overseas procurement to insure that all returns fea-

sible under acceptable price differentials are being made.

As a separate action, Lt. Gen. Andrew T. McNamara, formerly director of the Defense Supply Agency, will conduct an immediate review of Defense logistic and other support activities in France, Spain, Italy, and Japan and report to the Secretary of Defense where he feels further reductions might be made in personnel, facilities, and materiel required by these activities. No combat units will be redeployed to the United States as a result of this study.

In summary, the Department of Defense continues to be deeply committed to the effort to rectify the U.S. balance-of-payments position. We are attempting to reduce our own net expenditures entering the balance of payments to the maximum, consistent with our responsibilities to others, to our own national security, and to our own personnel overseas.

While our past achievements have been substantial, we are not satisfied. We believe that still more can be done and we will strive to do it.

U.S. defense expenditures and receipts entering the international balance of payments, fiscal years 1961-64

[In millions of dollars]

	1961 (actual)	1962 (actual)	1963 (actual)	1964 (preliminary)		1961 (actual)	1962 (actual)	1963 (actual)	1964 (preliminary)
Expenditures:					Expenditures—Continued				
U.S. forces and their support:					Military assistance program:				
Expenditures by U.S. military, civilians and dependents ¹	781.1	771.5	803.2	849.2	Offshore procurement	130.9	100.8	118.4	117.3
Foreign nationals (direct and contract hire)	362.2	394.1	432.3	423.4	NATO infrastructure	104.6	35.3	88.3	61.5
Procurement:					Other	74.8	90.6	109.0	59.0
Major equipment	61.0	66.7	75.8	91.4	Subtotal	310.3	226.7	315.7	237.8
Construction	158.0	121.7	100.9	80.0	Net change in dollar-purchased foreign currency holdings	-2.0	+13.3	-6.3	-8.0
Materials and supplies (include POL) ²	561.3	586.6	558.7	474.7	Total expenditures	2,763.2	2,700.6	2,816.7	2,763.0
Operation and maintenance (other) ³	521.3	520.0	536.4	420.2	Cash receipts ⁴	318.9	898.6	1,334.4	1,273.6
Other payments ³				194.3	Net adverse balance (DOD)	2,434.3	1,802.0	1,482.3	1,489.4
Subtotal	2,444.9	2,460.6	2,507.3	2,533.2	Other expenditures (AEC and other agencies included in NATO definition of defense expenditures)	343.4	276.0	248.1	134.0
					Net adverse balance (NATO definition)	2,777.7	2,078.0	1,730.4	1,623.4

¹ Includes expenditures for goods and services by nonappropriated fund activities.

² In fiscal year 1964, data for materials and supplies include only expenditures for O. & M. supplies and stock fund purchases.

³ In fiscal year 1964, "Operation and maintenance (other)" includes all O. & M. payments not included elsewhere and "Other payments" includes expenditures for retired pay, claims, research, and development, industrial fund activities, etc.

⁴ Cash receipts data include only (1) sales of military items through the U.S. Department of Defense; (2) reimbursements to the United States for logistical support of

United Nations forces and other nations' defense forces; and (3) sales of services and excess personal property. They do not include estimates of receipts for military equipment procured through private U.S. sources, except where these are covered by government-to-government agreements; i.e., with the Federal Republic of Germany beginning in fiscal year 1962. Fiscal year 1964 data also include approximately \$24,000,000 reflecting barter transactions.

U.S. defense expenditures and receipts entering the international balance of payments, fiscal years 1961-64

[In millions of dollars]

Country	1961 (actual)	1962 (actual)	1963 (actual)	1964 (preliminary)	Country	1961 (actual)	1962 (actual)	1963 (actual)	1964 (preliminary)
Australia ¹				10.5	Pakistan	8.2	6.4	4.5	5.6
Austria	6.1	5.6	4.4	3.8	Philippine Islands	44.7	44.1	50.4	44.8
Azores	6.8	5.4	5.4	5.4	Portugal	8.4	6.8	4.4	3.4
Bahrain Islands	39.5	42.8	34.8	31.2	Ryukyu Islands	84.1	97.9	101.6	126.1
Belgium-Luxembourg	19.6	14.0	14.2	11.1	Saudi Arabia	45.2	41.6	45.7	42.1
Bermuda Islands	13.1	14.0	13.1	11.7	Spain	54.6	54.7	47.8	46.8
Canada	396.9	321.6	322.0	272.0	Switzerland	8.4	5.2	7.1	8.8
China, Republic of	23.9	21.7	18.8	19.8	Thailand	4.7	15.8	29.0	27.4
Denmark-Greenland	47.5	37.9	37.5	38.5	Trinidad-Tobago	17.0	18.4	17.0	25.0
France	299.5	269.3	256.7	231.3	Turkey	65.4	56.6	45.0	62.3
Germany, Federal Republic of	641.4	698.6	733.8	706.4	United Kingdom	244.1	205.2	188.6	182.1
Greece	20.5	12.8	30.3	25.1	Venezuela ²				33.2
Iceland	14.1	13.6	10.5	13.9	Vietnam ²				56.2
Indochina ²	7.5	25.8	42.5		Other American Republics	60.6	63.2	73.7	52.5
Italy	97.7	85.8	100.3	95.0	Other	170.5	192.9	224.5	192.7
Japan	409.8	374.4	384.5	298.9	Total expenditures	3,096.6	2,976.6	3,064.8	2,897.0
Korea	99.2	108.9	99.3	92.9	Receipts	318.9	898.6	1,334.4	1,273.6
Morocco	21.4	19.8	17.5	11.3	Net adverse balance	2,777.7	2,078.0	1,730.4	1,623.4
Netherlands	35.1	31.8	29.0	33.7					
Netherlands-Antilles	64.3	54.0	52.2	56.6					
Norway	16.9	10.0	18.7	18.9					

¹ Included in "Other" through fiscal year 1963.

² Includes Laos, Cambodia, Vietnam through fiscal year 1963; beginning fiscal year 1964, Laos and Cambodia included in "Other" and Vietnam separately identified.

³ Included in "Other American Republics" through fiscal year 1963.

EXTENSION AND AMENDMENT OF CERTAIN EXPIRING PROVISIONS OF THE PUBLIC HEALTH SERVICE ACT

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of Calendar No. 112, the Senate bill 510.

The VICE PRESIDENT. The bill will be stated by title.

The LEGISLATIVE CLERK. A bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

The VICE PRESIDENT. Is there objection to the request of the Senator from Montana?

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on

Labor and Public Welfare with amendments on page 2, line 1, after the word "and", to strike out "such sums as may be necessary" and insert "\$8,000,000"; on page 3, after line 7, to insert:

(e) Paragraph 1 of subsection (c) is amended by inserting "on the basis of estimates" after "advance"; by striking out the comma after the word "reimbursement" and inserting in lieu thereof "(with necessary adjustments on account of underpayments or overpayments)."; and by adding at the end

of such paragraph the following sentence: "Nothing in this section shall be construed to require, or authorize any requirement of, any grantee to maintain a detailed record or provide a detailed report with respect to the age of individuals vaccinated with vaccines financed in whole or part under this section so long as such grantee maintains such records and makes such reports as the Surgeon General may require of the number of individuals actually vaccinated with such vaccines and which the Surgeon General finds that such number does not exceed the number of children estimated by him from time to time to be within the age group or groups eligible under this section to receive such vaccines."

On page 4, after line 1, to strike out:

Sec. 3. Section 310 of the Public Health Service Act is amended by striking out "the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964; and the fiscal year ending June 30, 1965" and inserting in lieu thereof "each fiscal year ending prior to July 1, 1970", and by striking out "any year" and inserting in lieu thereof "any year ending prior to July 1, 1955".

And, in lieu thereof, to insert:

Sec. 3. (a) Effective with respect to appropriations for fiscal years beginning after June 30, 1965, section 310 of the Public Health Service Act is amended by striking out "for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed \$3,000,000 for any year, as may be necessary" and inserting in lieu thereof "not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, \$9,000,000 for the fiscal year ending June 30, 1968, and \$10,000,000 each for the fiscal years ending June 30, 1969, and June 30, 1970,".

(b) Such section is further amended by inserting "including necessary hospital care, and" immediately after "agricultural migratory workers and their families," in clause (1) (ii) of such section.

On page 5, line 2, after "Sec. 4.", to insert "(a)"; and after line 5, to insert:

(b) The third sentence of subsection (c) of section 314 of such Act is amended by striking out "\$2,500,000" and inserting in lieu thereof "\$5,000,000".

So as to make the bill read:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "\$11,000,000" and by inserting "and \$8,000,000 for each of the next five fiscal years" immediately after "June 30, 1965,". The second sentence of such subsection is amended by striking out "the fiscal years ending June 30, 1963, and June 30, 1964" and inserting in lieu thereof "any fiscal year ending prior to July 1, 1970". The third sentence of such subsection is amended by striking "and tetanus" and inserting in lieu thereof "tetanus, and measles", and by striking out "under the age of five years" and inserting in lieu thereof "of preschool age".

(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of prac-

tical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future."

(c) Subsection (b) of such section is amended by striking out "of limited duration", by striking out "against poliomyelitis, diphtheria, whooping cough, and tetanus" and inserting in lieu thereof "against the diseases referred to in subsection (a)", and by striking out "who are under the age of five years" and inserting in lieu thereof "of preschool age".

(d) Such section is further amended by striking out "intensive community vaccination" wherever it appears in subsections (a), (b), and (c) and inserting in lieu thereof "immunization".

(e) Paragraph 1 of subsection (c) is amended by inserting "on the basis of estimates" after "advance"; by striking out the comma after the word "reimbursement" and inserting in lieu thereof "(with necessary adjustments on account of underpayments or overpayments)"; and by adding at the end of such paragraph the following sentence: "Nothing in this section shall be construed to require, or authorize any requirement of, any grantee to maintain a detailed record or provide a detailed report with respect to the age of individuals vaccinated with vaccines financed in whole or part under this section so long as such grantee maintains such records and makes such reports as the Surgeon General may require of the number of individuals actually vaccinated with such vaccines and which the Surgeon General finds that such number does not exceed the number of children estimated by him from time to time to be within the age group or groups eligible under this section to receive such vaccines."

MIGRATORY WORKERS HEALTH SERVICES

SEC. 3. (a) Effective with respect to appropriations for fiscal years beginning after June 30, 1965, section 310 of the Public Health Service Act is amended by striking out "for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed \$3,000,000 for any year, as may be necessary" and inserting in lieu thereof "not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, \$9,000,000 for the fiscal year ending June 30, 1968, and \$10,000,000 each for the fiscal years ending June 30, 1969, and June 30, 1970,".

(b) Such section is further amended by inserting "including necessary hospital care, and" immediately after "agriculture migratory workers and their families," in clause (1) (ii) of such section.

GENERAL PUBLIC HEALTH SERVICES

SEC. 4. (a) The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

(b) The third sentence of subsection (c) of section 314 of such Act is amended by striking out "\$2,500,000" and inserting in lieu thereof "\$5,000,000".

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

Mr. HILL. Mr. President, the Committee on Labor and Public Welfare has favorably reported S. 510, the Community Health Services Extension Amendments of 1965. This bill is a part of the President's health program and its enact-

ment is urged by the administration. When hearings were conducted by the Subcommittee on Health the spokesmen for the Department of Health, Education, and Welfare as well as numerous health organizations and agencies urged its enactment.

This bill would extend four existing grant-in-aid programs that are authorized by the Public Health Service Act.

IMMUNIZATIONS

Section 2 of the bill would extend for 5 additional years, fiscal years 1966-70, the authority for assisting the States in financing immunization programs against polio, diphtheria, whooping cough, and tetanus, through amendments to the Vaccination Assistance Act of 1962.

When we first considered the legislation in 1962, the testimony presented to the committee showed that only one-third of the children of preschool age had been vaccinated against polio. Since that time we have made great progress. The yearly number of cases of polio between 1954 and 1964 is down from 38,476 to 121, and decreases in diphtheria, whooping cough, and tetanus are also reported.

We know what a terrible disease polio has been, how contagious it has been, how much heartache and suffering have resulted from it, and the large number of deaths it has caused. During the past year, due to the new vaccine and the great program inaugurated by Congress, and in large measure due to that program, there were only 121 cases of polio, whereas 10 years ago the number of cases was 38,476.

But while our progress is gratifying, much more work remains to be done. Two-thirds of the children of preschool age have been immunized against polio. There is no reason why we cannot intensify our efforts and reach the remaining one-third of the preschool children who remain unprotected against the crippling disease of polio, a disease that can be conquered.

Since this legislation was enacted in 1962, a vaccine against measles has become available. We are proposing, therefore, to add measles as a disease that may be included in immunization programs.

Each year some 4 million individuals in the United States are afflicted with measles. Not only does measles result in many deaths, but it also results in residual brain damage and other residual damage to the human body. Physicians estimate there is some residual brain damage in 1 of every 1,000 cases of measles, and some 400 deaths are attributed to measles each year.

It may be of interest to the Senate to know that a precedent for this kind of legislation was set for Congress as far back as February 27, 1813, through the efforts of the immortal Thomas Jefferson. He gave material assistance in introducing smallpox vaccination in America. The act of 1813 authorized any citizen to apply for vaccine matter through post offices and exempted mail carrying vaccine matter from postage fees.

The bill as introduced provided for an open end on appropriations. However, the committee recommends an authorization of \$8 million for each of the 5 years, which is \$3 million less than the \$11 million authorized for the present year, fiscal 1965.

MIGRATORY WORKERS' HEALTH SERVICE

Section 3 of the bill would extend for 5 additional years, fiscal years 1966-70, the program of grants authorized by Public Law 87-692 to assist in financing health services for domestic migratory agricultural workers and their families.

The health services provided by this program are largely of a public health nature, such as maternal and child health clinics, vaccination programs, and case-finding surveys in such areas as tuberculosis.

Information presented at the hearings showed that it would be desirable to extend the scope of the health services provided to include hospitalization in short-term hospitals. Hospitals located in areas with heavy concentrations of migratory workers have great difficulty in meeting the expenses involved in providing emergency medical care to migrant workers whose incomes are very limited.

The committee recommends, therefore, that hospital care be included among the health services financed with Federal assistance.

The fact that the bracero program has been terminated will, according to testimony before the legislative committee and the Appropriations Committee, increase the demand for additional domestic migratory farmworkers. Also, the demand for funds will increase as more counties participate under the program. At present only 100 of the 1,000 counties with significant numbers of migratory health workers are receiving health services through the program. The funds available for fiscal year 1965 for migrant workers health grants will not be enough to fund the approved applications on hand as of January 1, 1965.

In approving a 5-year extension in the program of project grants for health services for migratory workers and their families, the committee recommends appropriation authorizations of \$7 million for 1966, \$8 million for 1967, \$9 million for 1968, and \$10 million each for 1969 and 1970. S. 510 as introduced authorized such sums as may be necessary in each of the 5 years.

FORMULA GRANTS TO STATES

Section 4 would extend for 1 additional year, fiscal year 1967, the formula grants for general assistance, mental health, dental health, radiological health, chronic diseases and public health schools. No change in the overall annual authorization of \$50 million is proposed.

Only a 1-year extension is recommended by the committee pending the completion of two major studies.

One of these major studies is being carried out by the Association of State and Territorial Health Officers.

In addition, the 4-year study of the National Commission on Community Health Services will be completed within a year. This study to develop improved methods of providing community health

services is under the direction of the well-qualified Mr. Marion Folsom. The sponsors are the American Public Health Association and the National Health Council.

In the case of the formula grants for schools of public health, however, the committee is of the opinion that to defer action would not be in the national interest. It is recommended, therefore, that the subceiling of \$2,500,000 earmarked for schools of public health under section 314(c) of the Public Health Service Act be raised to \$5 million with no increase in the overall appropriation authorization of \$50 million under such section.

The 12 schools of public health are a national resource. They serve as a source of professional public health personnel for all of the State and local governments and for all of the Federal agencies including the Public Health Service, the Department of Defense, and the Veterans' Administration.

Senators may recall that there are only 12 schools of public health in the entire United States. In other words, of the 50 States, only 10 have schools of public health; the remaining 40 States must look at the 12 schools for the training of doctors and public health nurses, public health technicians and other public health employees that they must have.

Last year Congress approved the graduate public health training amendments of 1964 that more than doubles the Federal support for public health training. The resultant expansion in professional public health students requires additional support to the schools of public health if they are to maintain the high level of training that is now offered.

In the near future two new schools of public health will be established. Unless the formula grants are increased there will be a reduction in the amounts available to the 12 existing schools of public health.

PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

The program of project grants for community health services were authorized by the Community Health Services and Facilities Act of 1961—Public Law 87-395. These grants finance studies, experiments, and demonstrations for the development of improved methods of providing health services to the chronically ill or aged persons.

Since these project grants, as well as the formula grants under section 314(c), are being studied by the State and Territorial Health Officers Association and by the National Commission on Community Health Services, this committee recommends no change at this time in the annual appropriation authorization of \$10 million and a 1-year extension until June 30, 1967.

HEARINGS

The Subcommittee on Health conducted hearings on S. 510 on January 27, 1965. Representatives from the Department of Health, Education, and Welfare and its Public Health Service appeared and testified in favor of the legislation that is a part of the President's health program.

The enactment of the legislation was

also urged by the Association of Schools of Public Health, the American Public Health Association, the State and Territorial Health Officers Association, the American Dental Association, the American Association of Dental Schools, and by interested individuals.

In testimony on an identical bill in the House of Representatives the American Medical Association recommended the enactment of the legislation and the extension of the four grant-in-aid programs.

AUTHORIZATION FOR APPROPRIATIONS

S. 510 would add \$144 million in appropriation authorization over the years 1966-70. The existing authorization of \$74 million for fiscal year 1965 for the four programs would increase to \$75 million for fiscal year 1966 and to \$76 million for fiscal year 1967.

Prior to fiscal year 1968 the committee will reconsider the appropriation authorizations for the formula grants under section 314(c) and the project grants under section 316. The present bill does not include authorizations for either of these grant programs for 1968, 1969, or 1970. The authorization under S. 510 for those years, therefore, is reduced to \$17 million in the case of 1968 and to \$18 million for each of the years 1969 and 1970.

When these programs come to an end after another year, there will be further study and consideration by the committee and by Congress.

Speaking on behalf of the Committee on Labor and Public Welfare, I urge the passage of the bill.

Mr. JAVITS. Mr. President, this bill is an extremely valuable and important one in respect of certain existing grants-in-aid programs. The provisions with respect to migratory workers and with respect to immunization are very important programs throughout the country.

I call attention to the fact that in the immunization program—and this will be important in a number of States, as it is in my State—we have made certain changes with respect to the eligibility of children which opens the program to more children. In short, we are dealing with preschool age children, instead of children under 5 years of age. Also, an amendment which I offered will permit the Surgeon General to relax the most burdensome bookkeeping requirements now imposed as to the ages of the children who receive federally financed inoculations. The Association of State Health Officers had testified to the difficulty which these requirements presently impose. This amendment will overcome the difficulty presented in cases in which, through fault of no one, a child requires immunization even though he has passed the age limit in the act.

I call attention to the significant inclusion by the bill of measles within the immunization program.

I am also very pleased that on my motion the annual authorization for the section 314 general public health services program has been increased from \$2.5 to \$5 million. This proposal was almost unanimously recommended by the distinguished witnesses at our hearings and by many other authorities in this field.

For these and other reasons, I know it is an excellent bill. It is most gratifying to me that the Senate will pass the bill. I have every expectation and hope that it may have favorable action in the House and speedily become law.

The PRESIDING OFFICER (Mrs. NEUBERGER in the chair). The question is on agreeing to the first committee amendment.

Mr. MANSFIELD. Madam President, I ask that the committee amendments be considered and agreed to en bloc.

The PRESIDING OFFICER. Without objection, the committee amendments are considered and agreed to en bloc.

The bill is open to further amendment. If there be no further amendment to be proposed, the question is on the engrossment and third reading of the bill.

The bill (S. 510) was ordered to be engrossed for a third reading, was read the third time, and passed.

Mr. HILL. Madam President, I move that the Senate reconsider the vote by which the bill was passed.

Mr. MANSFIELD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

FOREIGN OIL IMPORTS

Mr. TOWER. Madam President, I ask unanimous consent that there be printed in the RECORD a statement that I presented on March 10 to the Secretary of Interior during hearings on foreign-oil imports and a statement to the same hearing by Mr. J. A. Mull, Jr., of Wichita, Kans., chairman of the Liaison Committee of Cooperating Oil and Gas Associations.

There being no objection, the statements were ordered to be printed in the RECORD, as follows:

STATEMENT OF SENATOR JOHN G. TOWER TO THE SECRETARY OF THE INTERIOR DURING HEARINGS ON FOREIGN OIL IMPORTS FOR MARCH 10, 1965

As you know, my State is the largest oil producing State in the Nation. It has also suffered more than any other State in regard to the drastically declining oil and gas industry.

Since I have been in the U.S. Senate, I have received reams of mail and telegrams, hundreds of telephone calls, plus the many people who have called on me in my office concerned with the declining oil industry and the results that this situation has produced.

In my hometown of Wichita Falls, Tex., you will find former drilling contractors working as bank tellers, geologists working in grocery stores, petroleum engineers working as bookkeepers, and others in the industry working in fields other than their own.

There are other results as well. Due to the depressed condition of this vital industry, retail establishment and, in fact, whole towns are suffering. Business volume is down, real estate values are down, bank deposits are down; in fact, the whole economic picture in the affected areas is down.

For some time the independent oil producer has pleaded for help. No help has come forth. The major cause of their problem is the excessive oil import policy of this administration.

Total oil imports must be frozen, or rolled back if feasible, until health of the domestic oil producing industry has been restored and the trend toward greater exploratory drilling assured. In addition, appropriate means

must be found and applied to neutralize the economic advantage of foreign produced oil brought into this country. The present system is not working, and additional patchwork in what is already a crazy quilt of special deals is not the answer.

Today you have appearing before you the leadership of the independent oil industry, testifying in behalf of their failing industry. I ask you to give your fullest attention to their problems and to develop policies curtailing oil imports so this vital industry which is so important to our national security may survive.

STATEMENT BEFORE THE U.S. DEPARTMENT OF INTERIOR, WASHINGTON, D.C., RE U.S. OIL IMPORT PROGRAM BY J. A. MULL, JR., WICHITA, KANS., CHAIRMAN, LIAISON COMMITTEE OF COOPERATING OIL & GAS ASSOCIATIONS, MARCH 10-11, 1965

"An Appraisal of the Petroleum Industry of the United States" (January 1965) by John M. Kelly of the Department of Interior, states that the oil industry is in excellent condition and that imports are in balance. Unfortunately these statements are not true. The 12.2 ration is terribly out of balance because of loopholes and exceptions and only pertains to zones 1 through 4 or only 45 percent of total imports. It is true that major integrated importing oil companies are showing the highest incomes ever experienced. But left out and given no consideration are two segments of the business we consider of utmost importance to the welfare of the Nation.

The independent oilman and independent refiner are dead ducks. The reason that imports are even partially in balance is that the Department of Interior considers offshore drilling as interior oil—85 percent of the national growth has been offshore. The independent oilman essentially cannot participate in offshore drilling because costs for leases and drilling start in the millions. The same integrated major companies who import oil also own the offshore oil, and since the import formula calls for a ratio it is immediately apparent that as a major integrated company increases its offshore production it automatically can increase its imports. In other words, the faster they dig in the gulf the more foreign oil they can bring in. They gain from both ends of the deal.

Sandwiched between these two propositions is the independent oilman. He has had no growth—but instead has lost his market because the major companies are taking their markets where they have their oil. Kansas, for example, 5 years ago had a demand of 327,000 barrels per day—this month there is a demand for 280,000.

The independent has found ever increasing costs of steel and labor—in fact, every item associated with his business has gone up and up. The only exception to his increasing costs is drilling and the independent owns the rigs. Yet the price the independents produce has continued to deteriorate through actual price cuts, pipeline handling charges, amortization of pipelines and actual loss of market.

It should be borne in mind that the independent oilman historically has found 85 percent of all new reserves within the borders of the United States. Today, essentially no new reserves are being found. A typical State has lost reserves of an average of 30 million barrels per year and the trend swings downward. Kansas had 169 rigs running 5 years ago—today there are 42 rigs running. The independent oil business is being deserted like rats leaving a sinking ship. Our colleges throughout the Nation reflect that students are shying completely away from geology and petroleum engineering. In fact some of the schools are closing these departments.

Within the next 30 days 46 rigs are being auctioned in Texas. These rigs are being

sold piecemeal to replace parts on rigs fortunate enough to still have work. They will bring approximately 15 percent of value. No new equipment is being sold.

What does this mean to a State like Kansas where oil is the second largest industry? Many counties within the State receive as high as 47 percent of tax revenue from oil, but no wells are being drilled and no new reserves are being found. It is obvious since oil is a diminishing supply that these counties within a few short years must find a new source of 47 percent of tax revenue. County assessors are frantic in their attempt to maintain income impossible to obtain. You cannot get blood out of a turnip. The effects are beginning to be felt throughout the Nation, and it is the concern of every citizen because he is going to have to bear this tax burden.

Mr. Kelly, and others, have passed off the demise of the independent oilman as due to inefficiency. The simple answer to this is that there is hardly an independent oilman in business today who does not have as an active partner a major importing oil company, and if the independent were not efficient, in fact much more efficient than the major oil company, he would not be left in the position of operator. Efficiency is not the answer. The answer is that conditions are such that it is impossible for him to compete.

We point out that the 22 largest major importing oil companies in 1962 paid an average of 4 percent—due largely to tax credits on foreign oil—credits not allowed to the independent because he cannot own foreign oil. At the same time the 10 largest nonoil companies, such as General Motors, in this same year paid an average of 44 percent. The answer is obvious.

We contend that every barrel of foreign oil brought into the United States is a \$1.50 gift to the importing company and the independent oilman gets absolutely no benefit. Compete? Impossible. Gentlemen, something must be done to neutralize the advantage of foreign oil immediately.

The independent oilman observes, without understanding and without explanation, negotiations carried on by the State Department in regard to imports; Canada, Mexico, Venezuela. Frankly, we do not know who Mr. State Department is. We cannot find him, consult with him, or question the motives behind decisions. Nor can we understand imports that, as far as we can determine, do not benefit the Nation as a whole, but certainly eliminate our market.

We point out that the Department of Defense buys 216,000 barrels per day of foreign oil. Why can't at least a portion of this be bought from the interior of the United States?

We now seriously wonder if the small independent enterpriser, who built this great Nation, is considered dispensable. Because we note, with fear, many others in our same category suffering from imports: cattle, wool, steel, textiles, coal, soft woods, glass and even cotton. If the independent oilman is dispensable and is being wiped out—then what is the result to the Nation?

How important is it that our military machine be powered by interior oil? In case of a war how long could the Nation depend upon getting oil from the East, from Venezuela, or even from the gulf offshore? Could we expect to get oil from Canada when Canada only produces 75 percent of its consumption, but exports to the United States 300,000 barrels per day?

We are not authorities on military matters, but we do know that we don't have the reserves within the borders of the United States (eliminating offshore) to maintain domestic consumption, let alone a war machine.

Our decrease in reserves within the borders of the United States are alarming, and we reiterate, historically 85 percent of new re-

89TH CONGRESS
1ST SESSION

S. 510

IN THE HOUSE OF REPRESENTATIVES

MARCH 15, 1965

Referred to the Committee on Interstate and Foreign Commerce

AN ACT

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Community Health
4 Services Extension Amendments of 1965".

5 IMMUNIZATION PROGRAMS

6 SEC. 2. (a) The first sentence of subsection (a) of
7 section 317 of the Public Health Service Act is amended
8 by striking out "and" before "\$11,000,000" and by inserting
9 "and \$8,000,000 for each of the next five fiscal years"
10 immediately after "June 30, 1965,". The second sentence

1 of such subsection is amended by striking out “the fiscal years
2 ending June 30, 1963, and June 30, 1964” and inserting
3 in lieu thereof “any fiscal year ending prior to July 1, 1970”.
4 The third sentence of such subsection is amended by striking
5 “and tetanus” and inserting in lieu thereof “tetanus, and
6 measles”, and by striking out “under the age of five years”
7 and inserting in lieu thereof “of preschool age”.

8 (b) Subsection (a) of such section is further amended
9 by adding at the end thereof the following new sentence:
10 “Such grants may also be used to pay similar costs in connec-
11 tion with immunization programs against any other disease
12 of an infectious nature which the Surgeon General finds
13 represents a major public health problem in terms of high
14 mortality, morbidity, disability, or epidemic potential and to
15 be susceptible of practical elimination as a public health prob-
16 lem through immunization with vaccines or other preventive
17 agents which may become available in the future.”

18 (c) Subsection (b) of such section is amended by strik-
19 ing out “of limited duration”, by striking out “against polio-
20 myelitis, diphtheria, whooping cough, and tetanus” and
21 inserting in lieu thereof “against the diseases referred to in
22 subsection (a)”, and by striking out “who are under the age
23 of five years” and inserting in lieu thereof “of preschool
24 age”.

1 (d) Such section is further amended by striking out
2 “intensive community vaccination” wherever it appears in
3 subsections (a), (b), and (c) and inserting in lieu thereof
4 “immunization”.

5 (e) Paragraph 1 of subsection (c) is amended by insert-
6 ing “on the basis of estimates” after “advance”; by striking
7 out the comma after the word “reimbursement” and inserting
8 in lieu thereof “(with necessary adjustments on account of
9 underpayments or overpayments),”; and by adding at the
10 end of such paragraph the following sentence: “Nothing in
11 this section shall be construed to require, or authorize any
12 requirement of, any grantee to maintain a detailed record or
13 provide a detailed report with respect to the age of individ-
14 uals vaccinated with vaccines financed in whole or part under
15 this section so long as such grantee maintains such records
16 and makes such reports as the Surgeon General may require
17 of the number of individuals actually vaccinated with such
18 vaccines and which the Surgeon General finds that such
19 number does not exceed the number of children estimated by
20 him from time to time to be within the age group or groups
21 eligible under this section to receive such vaccines.”

22 MIGRATORY WORKERS HEALTH SERVICES

23 SEC. 3. (a) Effective with respect to appropriations for
24 fiscal years beginning after June 30, 1965, section 310 of

1 the Public Health Service Act is amended by striking out “for
2 the fiscal year ending June 30, 1963, the fiscal year ending
3 June 30, 1964, and the fiscal year ending June 30, 1965,
4 such sums, not to exceed \$3,000,000 for any year, as may
5 be necessary” and inserting in lieu thereof “not to exceed
6 \$7,000,000 for the fiscal year ending June 30, 1966,
7 \$8,000,000 for the fiscal year ending June 30, 1967,
8 \$9,000,000 for the fiscal year ending June 30, 1968, and
9 \$10,000,000 each for the fiscal years ending June 30, 1969,
10 and June 30, 1970,”.

11 (b) Such section is further amended by inserting “in-
12 cluding necessary hospital care, and” immediately after “ag-
13 ricultural migratory workers and their families,” in clause
14 (1) (ii) of such section.

15 GENERAL PUBLIC HEALTH SERVICES

16 SEC. 4. (a) The first sentence of subsection (c) of sec-
17 tion 314 of such Act is amended by striking out “first five
18 fiscal years ending after June 30, 1961” and inserting in lieu
19 thereof “first six fiscal years ending after June 30, 1961”.

20 (b) The third sentence of subsection (c) of section 314
21 of such Act is amended by striking out “\$2,500,000” and
22 inserting in lieu thereof “\$5,000,000”.

1 SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH
2 SERVICES

3 SEC. 5. The first sentence of subsection (a) of section
4 316 of such Act is amended by striking out "first five fiscal
5 years ending after June 30, 1961" and inserting in lieu
6 thereof "first six fiscal years ending after June 30, 1961".

Passed the Senate March 11, 1965.

Attest: FELTON M. JOHNSTON,
Secretary.

AN ACT

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

MARCH 15, 1965

Referred to the Committee on Interstate and Foreign
Commerce

Digest of CONGRESSIONAL PROCEEDINGS

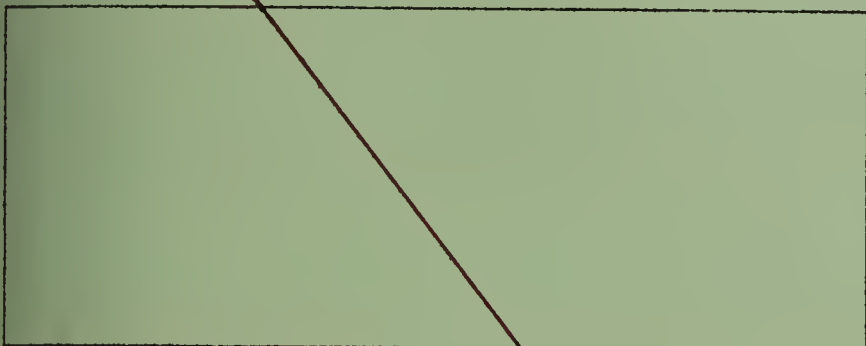
OF INTEREST TO THE DEPARTMENT OF AGRICULTURE
UNITED STATES DEPARTMENT OF AGRICULTURE

Washington, D. C. 20250
Official Business Postage and fees Paid
U. S. Department of Agriculture

OFFICE OF
BUDGET AND FINANCE

(For information only;
should not be quoted
or cited)

Issued April 16, 1965
For actions of April 15, 1965
89th-1st; No. 68



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HIGHLIGHTS: Rep. Lindsay commended foreign aid program, including use of surplus foods. Rep. Duncan introduced and discussed bill to establish Ore. Dunes National Seashore.

HOUSE

1. ELECTRIFICATION. Received from this Department a proposed bill to provide for the establishment of a Rural Electrification Administration Loan Account (a revolving fund) consisting of appropriations of loan funds, loan funds obtained by borrowing from the Treasury, unexpended balances, and notes, bonds, obligations, and property held on behalf of the Secretary of the Treasury, and collections therefrom; to Agriculture Committee. p. 7818
2. INSPECTION SERVICES. Received from this Department a proposed bill to amend the act of Aug. 28, 1950, which permits the Secretary of Agriculture to furnish, on a reimbursable basis, certain inspection services involving overtime work, so as to clarify geographic areas intended to be covered and to define types of inspection and quarantine services to be included; to Agriculture Committee. p. 7818
3. FARM PROGRAM. Rep. Purcell inserted Secretary Freeman's speech before a conference of farm organization leaders in Kansas City, Mo., reviewing farm programs and policies. pp. 7797-9

4. FOREIGN AID. Rep. Lindsay commended the foreign aid program, including the use of surplus foods for the needy abroad. pp. 7811-5
5. HEALTH. The Interstate and Foreign Commerce committee reported with amendments H. R. 2986, to extend provisions of the Public Health Service Act relating to community health services (H. Rept. 249), and H. R. 2984, to amend and extend the Public Health Service Act provisions for construction of health research facilities (H. Rept. 247). p. 7818
6. SOIL SURVEY. Received from Interior a report of a soil survey and land classification of lands in the Baker project, Ore. p. 7818
7. LEGISLATIVE ACCOMPLISHMENTS. Speaker McCormack reviewed and commended legislative accomplishments during the first 100 days of this session of Congress. p. 7795
8. LEGISLATIVE PROGRAM. Rep. Albert announced that S. 4, the water pollution control bill, will be considered Apr. 28 (pp. 7795-6). Unanimous consent was granted for the House to adjourn from Apr. 19 to Apr. 22, and from Apr. 22 to Apr. 26 (p. 7795).
9. ADJOURNED until Mon., Apr. 19. p. 7818

SENATE

Met briefly, but conducted no business, and adjourned until Mon., Apr. 19.
p. 7820

ITEMS IN APPENDIX

10. FARM PROGRAM. Extension of remarks of Rep. White expressing skepticism over certain provisions of the new farm bill and inserting an editorial analyzing the bill. pp. A1895-6
11. FARM LABOR. Rep. Talcott inserted a letter critical of a Department of Labor proposal to raise the wages of farm workers. pp. A1884-5
12. WORLD TRADE CENTER. Rep. Multer inserted an appraisal of the proposal to build a world trade center in New York City. pp. A1876-9
13. POVERTY. Rep. Udall inserted the report of the National Conference on Poverty in the Southwest "on the extent of the poverty suffered by Mexican-Americans, Indians, and other minority groups in the States comprising the Southwest." pp. A1881-2
14. PEACE CORPS. Rep. Joelson inserted an article commending the work of the Peace Corps. p. A1880

BILLS INTRODUCED

15. DISASTER RELIEF. H. R. 7530 by Rep. MacGregor, H. R. 7533 by Rep. Nelsen, H. R. 7536 by Quie and H. R. 7541 by Rep. Thomson, Wisconsin, to provide Federal assistance to restore and repair certain disaster areas in the State of Minnesota; to Public Works Committee.

COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965

APRIL 15, 1965.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. HARRIS, from the Committee on Interstate and Foreign Commerce, submitted the following

R E P O R T

[To accompany H.R. 2986]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 2986) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

Page 1, beginning in line 6, strike out "The" and all that follows down to and including the period in line 10, and insert in lieu thereof the following:

The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "June 30, 1965" and by inserting "and each of the next three fiscal years," immediately after "June 30, 1965,".

Page 2, line 4, strike out "1970" and insert in lieu thereof "1968".

On page 3, line 1, insert "(1)" immediately after "(d)".

On page 3, after line 4, insert the following:

(2) The heading of such section is amended by striking out "INTENSIVE VACCINATION" and inserting in lieu thereof "IMMUNIZATION".

Page 3, line 10, strike out "1970" and insert in lieu thereof "1968".

Page 3, beginning in line 10, strike out the comma and the following:

and by striking out "any year" and inserting in lieu thereof "any year ending prior to July 1, 1965"

PRINCIPAL PURPOSE OF THE BILL

The bill extends four current programs carried out under the Public Health Service Act relating to health services.

The bill extends the duration of the current immunization program for an additional 3 years and extends the coverage of the program to include assistance in immunization programs against measles and other diseases presenting a major public health problem.

The bill also extends for an additional 3 years the current program under which health services are provided to domestic agricultural migratory workers.

The current program authorizing \$50 million annually for grants to the States for health services under section 314(c) of the Public Health Service Act is extended for an additional year, and the program of special project grants for community health services authorizing appropriations up to \$10 million annually is also extended for an additional year. Both of these latter programs are under review by the Public Health Service and the Association of State and Territorial Health Officers, and the State and territorial mental health authorities.

HEARINGS—COST

The committee held 4 days of hearings on this and three other health bills on March 2, 3, 4, and 5, 1965. All witnesses who testified concerning this legislation favored the provisions contained in the reported bill.

The total new authorizations contained in the reported bill are as follows:

[In thousands]

	1966	1967	1968
Sec. 317 (immunization).....	\$11,000	\$11,000	\$11,000
Sec. 310 (migratory workers).....	3,000	3,000	3,000
Sec. 314(c) (general health).....	(1)	50,000	-----
Sec. 316 (special projects).....	(2)	10,000	-----
Total.....	14,000	74,000	14,000

¹ Current authorization \$50,000,000 annually.

² Current authorization \$10,000,000 annually.

IMMUNIZATION PROGRAMS

The first major program of Federal assistance for immunization programs was established in August 1955 with the enactment of the Poliomyelitis Vaccination Assistance Act under which the Public Health Service administered \$53.6 million in grants-in-aid to the States for the purchase of vaccine.

In 1962, the Congress enacted the Vaccination Assistance Act of 1962 authorizing project grants for a 3-year period to assist States and local communities in carrying out intensive vaccination programs against poliomyelitis, diphtheria, pertussis (whooping cough), and tetanus. A total of \$26,925,000 has been appropriated to carry out this program, and assistance has been provided for 35 statewide and 39 local projects.

It is impossible to determine accurately how many children have been immunized against these diseases under the current program because most immunizations were given by private physicians. It is estimated, however, that in the period 1962-64, approximately 58 million people under age 50 were protected with oral polio vaccine, and during this same period, 7 million children under age 15 received 4 or more injections providing protection against diphtheria, tetanus, and pertussis.

Although many programs in addition to the current Federal immunization program have contributed to the decline in the number of cases of diphtheria, tetanus, pertussis, and poliomyelitis occurring in the United States, the current program has contributed significantly. The Following table sets forth detailed figures on these diseases for the period 1950 through 1964, which demonstrate the dramatic decline in the occurrence of these diseases.

Detailed figures on various diseases, 1950-64

Year	Diphtheria		Tetanus		Pertussis		Polio (total)		Paralytic polio		Measles	
	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality
1950	5,796	410	486	336	120,718	1,118	33,300	1,904	(1)	279	319,124	468
1951	3,983	302	506	394	68,687	951	28,386	1,551	(1)	2106	530,118	683
1952	2,960	217	484	360	45,030	402	57,879	3,145	(1)	2110	683,077	618
1953	2,355	156	506	337	37,129	270	35,592	1,450	(1)	1,090	449,146	462
1954	2,041	145	524	334	60,886	373	38,476	1,368	18,308	1,046	682,720	518
1955	1,984	150	462	265	62,786	467	28,985	1,043	13,850	800	555,156	345
1956	1,568	103	468	246	31,732	266	15,140	566	7,911	440	611,936	530
1957	1,211	81	447	279	48,295	183	5,485	221	2,499	164	486,799	389
1958	918	74	445	303	32,148	177	5,787	255	3,697	185	763,094	552
1959	934	72	445	283	40,005	269	8,425	454	6,289	323	406,162	385
1960	1809	69	231	231	14,809	118	3,190	230	2,525	160	441,703	380
1961	617	68	379	242	11,468	76	1,312	90	988	71	423,919	434
1962	444	41	322	215	17,749	83	1,910	60	762	42	481,530	408
1963	314	(1)	325	(1)	17,135	(1)	449	(1)	396	(1)	385,156	(1)
1964 ⁴	306	(1)	271	(1)	(1)	(1)	121	(1)	94	(1)	490,590	(1)

¹ Not available.² Late effects of acute poliomyelitis.³ Preliminary figures.

As of March 27, 1965, a total of three cases of poliomyelitis occurring in the United States this year have been reported to the Communicable Disease Center of the Public Health Service in Atlanta, Ga. A total of 53 cases of diphtheria have been reported this year and a total of 40 cases of tetanus. Information on the incidence of pertussis is not available.

MEASLES VACCINE

In recent years measles has come to be recognized as a major health problem in the United States. It is estimated that approximately 4 million cases occur each year resulting in at least 500 deaths and in extensive complications and serious disability such as mental retardation, pneumonia, hearing disorders, and measles encephalitis (inflammation of the brain). Two vaccines have recently been developed, one with inactivated (killed) virus and one with attenuated (live) virus. Live vaccine is the vaccine of choice because it confers a longer period of immunity. When administered with gamma globulin, reaction to the vaccine occurs in about 15 percent of the cases, but there have been no serious complications resulting from use of the vaccine. For initial immunization, only one dose of the live vaccine (along with a dose of gamma globulin to minimize reactions) is needed, or three doses of killed vaccine may be administered at monthly intervals followed by one of live.

The establishment of a Federal program in this area is considered necessary because although the vaccines have been available since March 1963, there has been no decline in the incidence of measles and during 1964 the number of reported cases rose by more than 100,000. The major barriers to the greater use of the vaccine are considered to be (1) the high cost of the vaccine and (2) lack of public awareness of the seriousness of measles and the need to immunize against the disease.

It is estimated that 20 million preschool children will be immunized against measles under the program provided in the bill—8 million of the estimated 15 million currently susceptible preschoolers and 12 million newborn infants.

IMMUNIZATION PROGRAM PROPOSED IN THE BILL

The immunization program proposed in the bill will be as follows:

(1) Planned programs to achieve immunization against measles of all susceptible preschool children through increased clinic activity, programs in special problem areas, close cooperation with private physicians, and stepped-up public information and health education efforts.

(2) Simultaneous across-the-board activities to increase the immunization levels against diphtheria, pertussis, tetanus, and polio.

(3) Improved immunization maintenance programs with emphasis on protecting children during the first year of life but not ignoring booster programs for school-age children and adults.

Under the program, measles vaccine will be purchased for distribution at the State and local level. With respect to measles and the other listed diseases, appropriations also will be used for supporting activities, such as salaries and related expenses of additional State

and local health personnel needed to organize and promote comprehensive immunization programs.

IMMUNIZATION PROGRAMS AGAINST OTHER DISEASES

The reported bill authorizes grants to pay costs in connection with immunization programs against other diseases which the Surgeon General finds represent a major public health problem and which he determines to be susceptible of practical elimination as a public health problem through vaccines or other preventive agents which might become available in the future.

Currently, work is progressing on the development of the following vaccines:

- (1) Combined live vaccines—measles, smallpox, yellow fever.
- (2) Rubella (German measles) vaccine.
- (3) A new flu vaccine.

If any or all of these or other vaccines are developed during the 3-year life of the proposed program, it is intended that immunization programs may be established under the authorization of this legislation without the necessity of further legislative action by the Congress.

DOMESTIC MIGRATORY AGRICULTURAL WORKERS

In 1962, the Congress enacted legislation providing for grants for family health service clinics and other health services for domestic migratory agricultural workers and their families. The current program expires June 30, 1965, and the bill extends this program for an additional 3 years.

It is proposed under the bill to continue existing programs, including payment to the extent funds are available for costs of hospitalization in short-term general hospitals.

About 1 million persons including workers and family dependents move during each crop season in response to seasonal farm labor demand. They live and work for brief periods in nearly one-third of the Nation's counties. Their health needs are acute as a result of their low income, lack of education and understanding of good health practices, geographic isolation from communities and their health services, and constant ineligibility for the health care afforded indigent residents because they lack permanent resident status anywhere.

In the United States today, the self-perpetuating conditions of illiteracy, insecurity, and poverty dominate the life of the domestic migrant farmworker. The migratory work force is composed chiefly of southern Negroes, Americans of Mexican descent, American Indians, and Puerto Ricans.

Domestic migrants move one or more times each year in search of work along three major migration routes—from Florida along the east coast to New England, from Texas to the Rocky Mountain and Central States, and from California north into the Pacific Northwest. They may be away from the place they call home for periods of a few weeks to most of the year.

Their wage rates are low compared with those in industry, and their periods of work are interrupted by travel between jobs and periods when no work is available. Thus, their annual earnings average less than \$1,000 per worker.

Although the number of family farms and self-employed farmworkers has declined in recent years, the number of large farms—the chief employers of hired farm labor—has increased. Domestic migrants included one-fifth of the Nation's total seasonal hired farm labor force at the 1963 peak. They continue to perform a vital role in modern agriculture for a third of our Nation's counties.

The Public Health Service has assisted 60 county or multi-county projects in 29 States and in the Commonwealth of Puerto Rico. Slightly more than 50 percent of these projects established family health service clinics. Forty percent of the total budgeted costs have been met through non-Federal funds. The majority of the project grants are for less than \$20,000 as shown below:

Amount of grant:	Percent
Less than \$5,000.....	7
\$5,000 to \$19,000.....	48
\$20,000 to \$49,000.....	28
\$50,000 or more.....	17

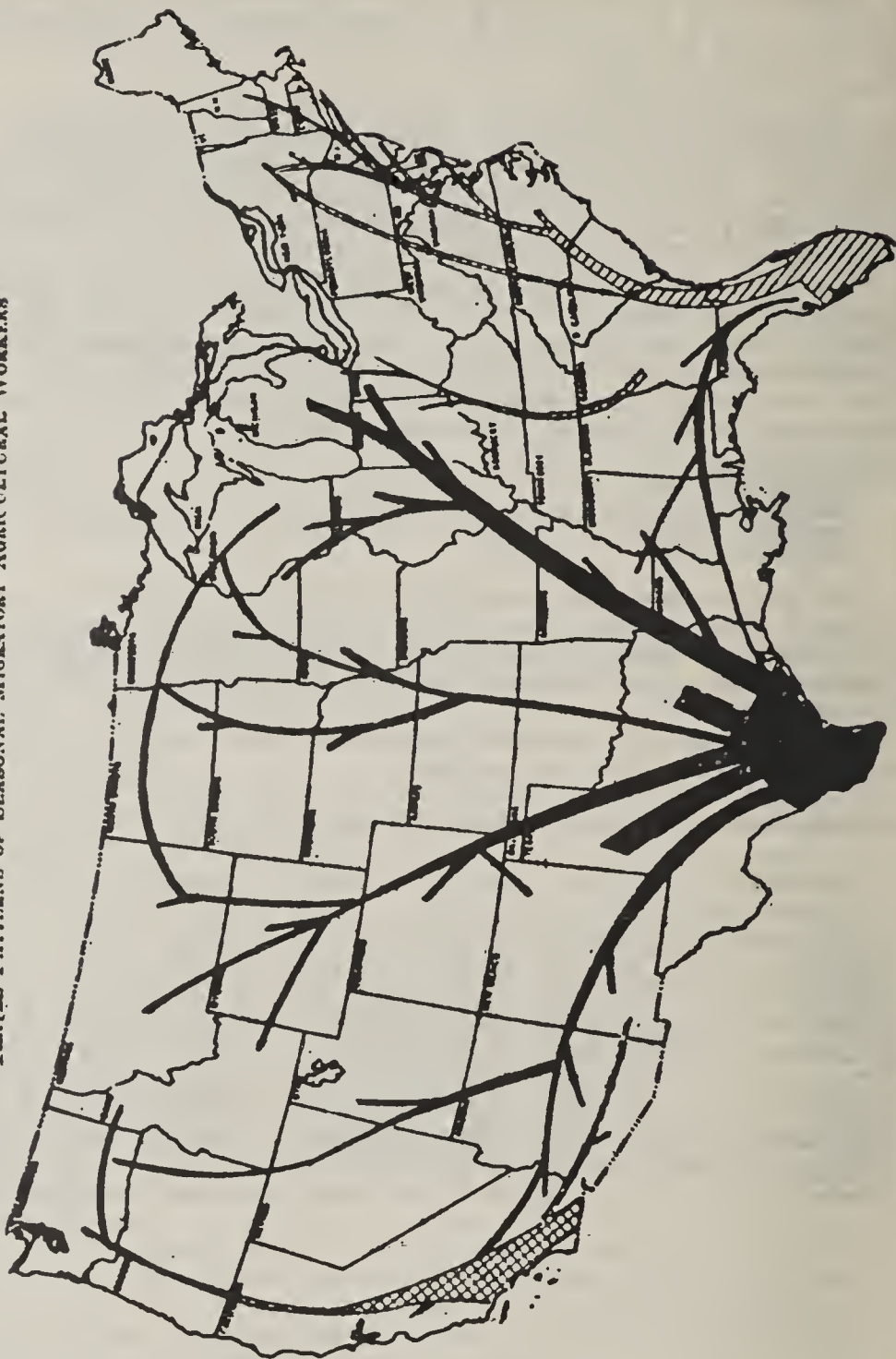
The projects vary from one locality to another in the nature and scope of their service. They provide medical treatment for illness or injury, immunizations, case finding and treatment of communicable diseases, prenatal and postnatal care and other preventive and curative services.

The following table shows migrant health project awards by State during the 3-year life of the program.

Migrant health project grant awards, by State, fiscal years 1963, 1964, and 1965

State	1963	1964	1965	State	1963	1964	1965
Arizona.....	82,431	191,954	271,333	New Jersey.....	130,669	120,000	100,000
Arkansas.....	22,640	12,095	22,640	New Mexico.....	2,070	3,100	3,100
California.....	0	389,339	483,514	New York.....	11,612	21,597	24,217
Colorado.....	37,433	34,443	59,512	North Carolina.....	27,420	0	40,785
Connecticut.....	0	2,070	2,810	Ohio.....	64,577	87,063	137,314
Delaware.....	0	9,025	9,541	Oklahoma.....	0	0	66,364
Florida.....	14,462	91,228	269,851	Oregon.....	62,620	75,474	97,548
Indiana.....	30,000	15,290	30,000	Pennsylvania.....	22,339	33,261	62,921
Iowa.....	5,800	2,600	5,400	Puerto Rico.....	0	0	66,757
Kansas.....	0	47,520	57,772	South Carolina.....	36,689	25,973	36,689
Louisiana.....	0	6,259	6,250	Texas.....	103,007	108,013	229,147
Maryland.....	8,500	7,725	7,725	Virginia.....	4,920	50,594	41,326
Massachusetts.....	0	20,250	21,008	Washington.....	30,975	28,516	37,658
Michigan.....	25,912	41,291	72,021	Wisconsin.....	0	0	7,399
Minnesota.....	5,924	41,092	52,157				
Nebraska.....	0	0	31,532	Total.....	750,000	1,500,000	2,353,782

TRAVEL PATTERNS OF SEASONAL MIGRATORY AGRICULTURAL WORKERS



Each spring the migrants move northward, returning in the fall to Florida, Texas, and the Southwest when no work can be found elsewhere.

Source: U.S. Department of Labor, Bureau of Employment Security, 1961.



★ State with one or more grant-assisted projects.

GENERAL PUBLIC HEALTH SERVICES

Section 314(c) of the Public Health Service Act authorizes appropriations annually of not to exceed \$50 million to enable the Surgeon General to assist, through grants and otherwise, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public health services. Of this sum, not to exceed \$2,500,000 is authorized annually to enable the Surgeon General to make grants-in-aid for provision in public or nonprofit schools of public health of comprehensive professional training, and other assistance, with allotments made giving primary consideration to the number of federally sponsored students attending each such school.

Currently, this program is being studied within the Department of Health, Education, and Welfare. In addition, the Public Health Service is undertaking a joint review with the Association of State and Territorial Health Officers and State and territorial mental health authorities of these programs for the purpose of determining the effectiveness of the programs, and determining appropriate legislative recommendations with respect thereto. In addition, these studies would cover the program of special project grants for community health services initially authorized in 1961 by the enactment of section 316 of the Public Health Service Act.

The bill extends the program under section 314(c) and 316 for 1 additional year. The purpose of the 1-year extension is to permit a thorough study of these programs and development of necessary legislative recommendations to increase their usefulness.

Under section 314(c), the Public Health Service now makes grants to States for the provision of general health services, mental health services, radiological health services, dental health services, and health services for the chronically ill and aged. The 1965 appropriations for these programs and their distribution are shown in the following table:

TABLE I.—1965 appropriations for health services as authorized under sec. 314(c) of Public Health Service Act

General health.....	\$10, 000, 000
Mental health.....	6, 750, 000
Chronic illness and aged.....	11, 750, 000
Radiological health.....	2, 500, 000
Dental health.....	520, 000
Formula grants to schools of public health.....	2, 500, 000

TABLE II.—1965 appropriations for health services as authorized under sec. 314(c) of Public Health Service Act

State or territory	General health	Mental health	Chronic illness and aged	Radiological health	Dental health
Total.....	\$10, 000, 000	\$6, 750, 000	\$11, 750, 000	\$2, 500, 000	\$520, 000
Alabama.....	247, 300	118, 100	268, 200	43, 200	10, 000
Alaska.....	28, 800	65, 000	60, 000	15, 000	10, 000
Arizona.....	100, 700	65, 000	79, 900	18, 900	10, 000
Arkansas.....	156, 700	67, 500	189, 600	27, 100	10, 000
California.....	679, 400	496, 000	762, 900	199, 400	10, 000
Colorado.....	109, 700	65, 000	103, 600	34, 700	10, 000
Connecticut.....	97, 800	74, 000	118, 900	29, 400	10, 000
Delaware.....	18, 800	65, 000	60, 000	15, 000	10, 000
District of Columbia.....	28, 100	65, 000	60, 000	15, 000	5, 000
Florida.....	306, 300	177, 400	399, 700	71, 500	10, 000
Georgia.....	276, 400	140, 200	284, 400	53, 700	10, 000
Hawaii.....	37, 400	65, 000	60, 000	15, 000	10, 000
Idaho.....	60, 100	65, 000	60, 000	20, 700	10, 000
Illinois.....	404, 800	289, 500	507, 400	107, 100	10, 000
Indiana.....	229, 700	142, 100	282, 400	50, 700	10, 000
Iowa.....	152, 600	86, 000	204, 100	35, 000	10, 000
Kansas.....	131, 200	68, 500	152, 100	26, 200	10, 000
Kentucky.....	212, 600	105, 900	257, 000	41, 100	10, 000
Louisiana.....	226, 400	115, 200	232, 700	46, 900	10, 000
Maine.....	72, 000	65, 000	75, 900	15, 000	10, 000
Maryland.....	142, 700	95, 900	147, 900	36, 100	10, 000
Massachusetts.....	215, 100	150, 200	293, 500	68, 300	10, 000
Michigan.....	374, 400	241, 500	417, 900	93, 200	10, 000
Minnesota.....	187, 500	107, 500	230, 400	48, 200	10, 000
Mississippi.....	212, 600	89, 900	233, 200	35, 900	10, 000
Missouri.....	212, 500	130, 200	290, 600	53, 900	10, 000
Montana.....	55, 400	65, 000	60, 000	15, 000	10, 000
Nebraska.....	91, 800	65, 000	101, 700	18, 700	10, 000
Nevada.....	32, 400	65, 000	60, 000	15, 000	10, 000
New Hampshire.....	39, 300	65, 000	60, 000	15, 000	10, 000
New Jersey.....	252, 500	183, 200	301, 900	64, 900	10, 000
New Mexico.....	78, 300	65, 000	60, 000	18, 300	10, 000
New York.....	670, 700	497, 200	846, 900	223, 500	10, 000
North Carolina.....	322, 400	162, 900	324, 600	62, 900	10, 000
North Dakota.....	56, 300	65, 000	60, 000	15, 000	10, 000
Ohio.....	464, 300	302, 200	553, 800	115, 500	10, 000
Oklahoma.....	156, 700	80, 200	185, 300	32, 000	10, 000
Oregon.....	105, 400	65, 000	113, 600	24, 300	10, 000
Pennsylvania.....	532, 900	341, 900	682, 400	145, 500	10, 000
Rhode Island.....	42, 700	65, 000	60, 000	15, 000	10, 000
South Carolina.....	193, 100	89, 500	183, 400	38, 500	10, 000
South Dakota.....	62, 100	65, 000	60, 000	15, 000	10, 000
Tennessee.....	253, 200	126, 700	288, 000	59, 700	10, 000
Texas.....	571, 600	325, 700	602, 200	120, 000	10, 000
Utah.....	72, 500	65, 000	60, 000	21, 300	10, 000
Vermont.....	34, 000	65, 000	60, 000	15, 000	10, 000
Virginia.....	249, 000	138, 800	251, 500	53, 000	10, 000
Washington.....	149, 200	90, 500	169, 400	42, 700	10, 000
West Virginia.....	117, 100	65, 000	139, 600	24, 000	10, 000
Wisconsin.....	204, 200	123, 400	255, 000	48, 300	10, 000
Wyoming.....	35, 000	65, 000	60, 000	15, 000	10, 000
Guam.....	7, 500	65, 000	60, 000	10, 000	5, 000
Puerto Rico.....	223, 800	98, 200	198, 400	35, 500	5, 000
Virgin Islands.....	5, 000	65, 000	60, 000	5, 200	5, 000

12 COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS

Allocations, fiscal year ending June 30, 1965—\$2,500,000 in grants to schools of public health for the provision of public health training (Public Health Service Act, sec. 314(c)(2))

Name of school	Average number of federally sponsored students	Percent of federally sponsored students	$\frac{2}{3}$ on basis of federally sponsored students	$\frac{1}{3}$ equally divided	Total (rounded to nearest \$100)
California.....	123.53	11.49	\$191,509.57	\$69,437.50	\$261,000
California, Los Angeles.....	44.92	4.18	69,670.15	69,437.50	139,100
Columbia.....	50.33	4.68	78,003.90	69,437.50	147,400
Harvard.....	68.94	6.41	106,838.68	69,437.50	176,300
Johns Hopkins.....	97.75	9.09	151,507.58	69,437.50	220,900
Michigan.....	178.27	16.58	276,347.15	69,437.50	345,800
Minnesota.....	155.94	14.50	241,678.75	69,437.50	311,100
North Carolina.....	146.42	13.62	227,011.35	69,437.50	296,500
Pittsburgh.....	68.83	6.40	106,672.00	69,437.50	176,100
Puerto Rico.....	57.00	5.30	88,337.75	69,437.50	157,800
Tulane.....	53.33	4.96	82,670.80	69,437.50	152,100
Yale.....	30.00	2.79	46,502.32	69,437.50	115,900
Total.....	1,075.26	100.00	1,666,750.00	833,250.00	2,500,000

PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

Under section 316 of the Public Health Service Act (project grants for community health services), financial assistance is provided to States and other public or nonprofit private agencies to undertake studies, experiments, and demonstrations looking toward the development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons. Under this program, the Public Health Service has made grants for 187 projects in 40 States. A listing of these projects is set forth in the hearings.

Appropriations for section 316 have totaled \$22,950,000 for the fiscal years 1962 through 1965. Current authorizations, which would be extended for an additional year, are for \$10 million in annual appropriations; however, the current level of appropriations is at the rate of \$7 million annually.

The bill extends the authorization of section 316 of the Public Health Service Act for an additional year, pending completion of the study of this program currently being conducted by the Public Health Service, the Association of State and Territorial Health Offices, and the State and territorial mental health authorities.

SECTION-BY-SECTION DESCRIPTION OF THE BILL AS REPORTED

Section 1. Short title

This section provides that this legislation may be cited as the "Community Health Services Extension Amendments of 1965."

Section 2. Immunization programs

This section amends section 317 of the Public Health Service Act under which the Surgeon General makes grants to the States, and in certain cases to instrumentalities of the States and political subdivisions of the States, to pay a portion of the cost of immunization programs against poliomyelitis, diphtheria, whooping cough, and tetanus. The amendments made by this section would—

(1) extend this program for the 3 fiscal years in the period beginning July 1, 1965, and ending on June 30, 1968, at the present authorization ceiling of \$11 million per year;

(2) extend the program to cover the costs of immunization programs against measles and other diseases of an infectious nature which the Surgeon General finds represent a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future;

(3) change the group with respect to which such immunization programs may be carried out from children under the age of 5 years to children of preschool age; and

(4) eliminate the present requirement that such immunization programs be of limited duration.

Section 3. Migratory workers health services

This section amends section 310 of the Public Health Service Act so as to extend for 3 additional years (fiscal years 1966, 1967, and 1968) the program of grants for family health service clinics for domestic agricultural migratory workers now being carried on under that section. The authorized appropriation would be \$3 million for each of such 3 fiscal years which is the amount presently authorized for such grants.

Section 4. General public health services

This section extends for 1 additional year the program carried on under section 314(c) of the Public Health Service Act under which the Surgeon General makes grants to assist in establishing and maintaining adequate public health services in the several States, including grants for demonstrations and for training of personnel for State and local public health work. The present authorization of appropriations of \$50 million per year would apply during the year for which this program is extended.

Section 5. Special project grants for community health services

This section extends for 1 additional year the program which is carried on under section 316 of the Public Health Service Act under which grants are made to States or other public or nonprofit private agencies or organizations for studies, experiments, and demonstrations looking toward development of new or improved methods of providing health services outside of hospitals, particularly for chronically ill or aged persons. The present authorization ceiling of \$10 million per year would apply to this additional year for which this program is extended.

AGENCY REPORTS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, March 2, 1965.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of February 15, 1965, for a report on H.R. 2986, a bill to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health service, and for other purposes. The proposal would be cited as the "Community Health Services Extension Amendments of 1965."

H.R. 2986 is the administration's proposal to implement one of the President's recommendations contained in his health message of January 7, 1965. We strongly recommend its enactment.

Inasmuch as we are scheduled to testify on this bill on Tuesday, March 2, we shall not burden this report with a detailed justification of its provisions. We are, however, enclosing for your convenience a section-by-section analysis of the bill.¹

Sincerely,

WILBUR J. COHEN,
Assistant Secretary.

DEPARTMENT OF AGRICULTURE,
Washington, D.C., March 24, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives Washington, D.C.*

DEAR MR. CHAIRMAN: This is in reply to your request of February 22 for our views on H.R. 2986, a bill to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

This Department favors this bill and recommends that it be passed. The bill slightly amends and extends certain provisions of several sections of the Public Health Service Act (as amended by various public laws in 1961 and 1962). Provisions relating to grants for intensive vaccination programs and to grants for family health service clinics for domestic agricultural migratory workers are extended through June 30, 1970. Provisions regarding general public health services and special project grants for community health services are extended for 1 additional year beyond the original time period of the act, or in effect through June 30, 1967.

We believe that the programs included under these sections are greatly in the public interest and that provisions for their continuance as provided for by H.R. 2986 are essential. We are particularly concerned that steps already taken to improve the health services available to migratory workers be continued and extended to geographical areas which still offer inadequate services.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

CHARLES S. MURPHY,
Under Secretary.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., March 4, 1965.

B-74254.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.*

DEAR MR. CHAIRMAN: By letter dated February 15, 1965, you requested our comments on H.R. 2986. The purpose of this measure is to extend and otherwise amend certain expiring provisions of the Public Health Service Act, as amended.

¹ This section-by-section analysis is omitted from this report, but is printed in the hearings.

We have no special information that would assist your committee in its consideration of this measure and therefor offer no comments with regard thereto.

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., March 8, 1965.

HON. OREN HARRIS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, 1334 House Office Building,
Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your requests for views of the Bureau of the Budget on H.R. 2984, a bill to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes; H.R. 2985, a bill to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers; H.R. 2986, a bill to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes; and H.R. 2987, a bill to authorize mortgage insurance loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry.

H.R. 2984 carries out the President's recommendation contained in his health message to the Congress that the authority to assist in the construction of health research facilities be increased and extended for 5 years with provision for a larger Federal share for specialized research facilities of a national or regional character. The bill also includes new authority for research contracts and would create three additional Assistant Secretaries in the Department of Health, Education, and Welfare.

The Nation's first major step to provide improved community care for the mentally ill was passage of the community mental health facilities construction legislation by the last Congress. However, partial support of operating costs is required if the full benefit of community oriented care is to be reached. Few communities have the funds to provide full support of adequate services during the initial stages of operations. Many communities with the greatest need will not be able to participate without the type of support authorized in H.R. 2985.

H.R. 2986 provides for extension through fiscal year 1970 of the existing Public Health Service community vaccination and migratory agricultural workers health programs. The vaccination program would be expanded to provide protection against measles and such other infectious diseases which the Surgeon General finds to be a major health problem. This legislation also proposes a 1-year extension of the general health grant and special project grants for improving

community health services for which the authorization expires at the close of fiscal year 1966.

The President, in his health message, recommended aid to group practice facilities as needed to secure the greatest utilization of the available supply of doctors and dentists and to provide a wide range of out-of-hospital services. Such support is contained in H.R. 2987 which authorizes the Surgeon General to insure mortgage secured loans for the constructions of group practice facilities and to make direct loans if he finds that the applicant is unable to secure financing from other sources.

All four bills are important parts of, and in accord with, the President's health program for the Nation.

Sincerely yours,

PHILLIP S. HUGHES,
Assistant Director for Legislative Reference.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

PART A—RESEARCH AND INVESTIGATION

* * * * *

GRANTS FOR FAMILY HEALTH SERVICE CLINICS FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

SEC. 310. There are hereby authorized to be appropriated for [the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965] *each fiscal year ending prior to July 1, 1968*, such sums not to exceed \$3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishing and operating of such clinics, and (ii) special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families.

PART B—FEDERAL-STATE COOPERATION

* * * * *

GRANTS AND SERVICES TO STATES

SEC. 314. (a) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention, treatment, and control of venereal diseases, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment, and control of such diseases, including the training of personnel for State and local health work, and to enable him to prevent and control the spread of the venereal diseases in interstate traffic, and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to the venereal diseases, and to administer this section with respect to such diseases, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subsection.

(b) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention, treatment, and control of tuberculosis, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment, and control of such disease, including the provision of appropriate facilities for care and treatment and including the training of personnel for State and local health work, and to enable him to prevent and control the spread of tuberculosis in interstate traffic, and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to tuberculosis, and to administer this section with respect to such disease, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1945, the sum of \$10,000,000, and for each fiscal year thereafter a sum sufficient to carry out the purposes of this subsection.

(c) To enable the Surgeon General to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public health services, including grants for demonstrations and for training of personnel for State and local health work, there is authorized to be appropriated for each of the first **[five]** *six* fiscal years ending after June 30, 1961, the sum of \$50,000,000. When so provided in any Act appropriating funds for carrying out the purposes of this subsection for any year, such amounts as may be specified in such Act shall be available only for allotments and payments for such services and activities included under this subsection as may be provided in such Act; and in such case the requirements of subsection (h) shall be separately applied to such allotments and payments. Of the sum appropriated for each fiscal year pursuant to this subsection there shall be available (1) such amount as may be necessary to enable the Surgeon General to provide demonstrations and to

train personnel for State and local health work and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist States in carrying out the purposes of this subsection, and (2) an amount not to exceed \$2,500,000 to enable the Surgeon General to make grants-in-aid, under such terms and conditions as may be prescribed by regulations, for provision in public or nonprofit schools of public health accredited by a body or bodies recognized by the Surgeon General, of comprehensive professional training, specialized consultive services, and technical assistance in the fields of public health and in the administration of State and local public health programs, except that in allocating funds made available under this clause (2) among such schools of public health the Surgeon General shall give primary consideration to the number of federally sponsored students attending each such school.

(d) For each fiscal year, the Surgeon General, with the approval of the Administrator, shall determine the total sum from the appropriation under subsection (a), the total sum from the appropriation under subsection (b), and, within the limits specified in subsection (c), the total sum from the appropriation under that subsection which shall be available for allotment among the several States. He shall, in accordance with regulations, from time to time make allotments from such sums to the several States on the basis of (1) the population, (2) the extent of the venereal-disease problem, the extent of the tuberculosis problem, and the extent of the mental health problem and other special health problems, respectively, and (3) the financial need of the respective States. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

(e) To enable the Surgeon General to carry out the purposes of part B of title IV and to assist, through grants, States, counties, health districts, and other political subdivisions of the State, and public and nonprofit agencies, institutions, and other organizations, in establishing and maintaining organized community programs of heart disease control, including grants for demonstrations and the training of personnel, there is hereby authorized to be appropriated for each fiscal year such sums as may be necessary for such purposes. For each fiscal year, the Surgeon General, with the approval of the Secretary, shall determine the total sum from the appropriation under this subsection which shall be available for allotment among the several States, and shall, in accordance with regulations, from time to time make allotments from such sum to the several States on the basis of (1) the population and (2) the financial need of the respective States. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

(f) The Surgeon General, with approval of the Secretary, shall from time to time determine the amounts to be paid to each State from the allotments to such State, and shall certify to the Secretary of the Treasury, the amounts so determined, reduced or increased, as the case may be, by the amounts by which he finds that estimates of required expenditures with respect to any prior period were greater or less than the actual expenditures for such period: *Provided*, That in the case of amounts to be paid from allotments to any State under subsection (e), the Surgeon General may determine and certify to

the Secretary of the Treasury amounts to be paid to a county health district, other political subdivision of the State or to any public or nonprofit agency, institution, or other organization has in the State, if he finds that payment to such subdivision or other organization has been recommended by the State health authority of the State, and (1) that the State health authority has not, prior to August 1 of the fiscal year for which the allotment is made, presented and had approved a plan in accordance with subsection (g), or (2) that the State health authority is not authorized by law to make payments to such other organization. Upon receipt of such certification, the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay in accordance with such certification.

(g) The moneys so paid to any State, or to any political subdivision or other organization, shall be expended solely in carrying out the purposes specified in subsection (a), or subsection (b), or subsection (c), or subsection (e), as the case may be, and in accordance with plans, approved by the Surgeon General, which have been presented by the health authority of such State, or, under the circumstances specified in subsection (f)(1), by the political subdivision, or the agency, institution or other organization to whom the payment is made, and, to the extent that any such plan contains provisions relating to mental health, by the mental health authority of such State.

(h) Money so paid from allotments under subsections (a), (b), (c), and (e), shall be paid upon the condition that there shall be spent in such State for the same general purpose from funds of such State and its political subdivisions (or in the case of payments to a political subdivision or to an agency, institution or other organization under circumstances specified in subsection (f)(1), from funds of such political subdivision or organization), an amount determined in accordance with regulations.

(i) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of the State (or, in the case of payments to any political subdivision or any agency, institution, or other organization under the circumstances specified in subsection (f)(1), such subdivision or organization) finds that, with respect to money paid to the State, subdivision, or organization out of appropriations under subsection (a), or subsection (b), or subsection (c), or subsection (e), as the case may be, there is a failure to comply substantially with either—

- (1) the provisions of this section;
- (2) the plan submitted under subsection (g); or
- (3) the regulations;

the Surgeon General shall notify such State health authority or mental health authority, political subdivision, or organization that further payments will not be made to the State subdivision, or organization from appropriations under such subsection (or in his discretion that further payments will not be made to the State, subdivision, or organization from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be any such failure. Until he is so satisfied the Surgeon General shall make no further certification for payment to such State, subdivision, or orga-

nization from appropriations under such subsection, or shall limit payment to activities in which there is no such failure.

(j) All regulations and amendments thereto with respect to grants to States under this section shall be made after consultation with a conference of the State health authorities and, in the case of regulations or amendments which relate to or in any way affect grants under subsection (c) for work in the field of mental health, the State mental health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of any such regulations or amendments, of the State health authorities, and in the case of regulations or amendments which relate to or in any way affect grants under subsection (c) for work in the field of mental health, the State mental health authorities.

(k) Funds appropriated under subsection (a) and funds appropriated under subsection (b), in addition to being available for payments to States, shall also be available for expenditure by the Surgeon General in otherwise carrying out the respective subsections, including expenditures for printing and binding of the findings of investigations, and for pay and allowances and traveling expenses of personnel of the Service engaged in activities authorized by the respective subsections.

(l) Except as otherwise provided in this subsection the provisions of this section shall be applicable to Guam and American Samoa in the same manner in which they apply to the States. Amounts paid to Guam or American Samoa from its allotment under subsections (a), (b), (c), or (e) of this section, together with matching funds of Guam or American Samoa, respectively, may, with the approval of the Surgeon General, be expended in carrying out the purposes specified in any such subsection or subsections other than the one under which the allotment was made.

(m) The Surgeon General, at the request of the State health authority or, where appropriate, the State mental health authority, may reduce the payments to a State under this section by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Public Health Service to the State or any of its political subdivisions when such detail is made for the convenience of and at the request of the State and for purposes of carrying out its State plan approved under this section. The amount by which such payments are so reduced shall be available for payment of such costs by the Surgeon General, but shall, for purposes of subsection (h), be deemed to have been paid to the State.

HEALTH EDUCATION AND INFORMATION

SEC. 315. From time to time the Surgeon General shall issue information related to public health, in the form of publications or otherwise, for the use of the public, and shall publish weekly reports of health conditions in the United States and other countries and other pertinent health information for the use of persons and institutions engaged in work related to the functions of the Service.

SPECIAL PROJECT GRANTS FOR IMPROVING COMMUNITY HEALTH SERVICES

SEC. 316. (a) There are hereby authorized to be appropriated for each of the first **[five]** *six* fiscal years ending after June 30, 1961, the sum of \$10,000,000, for grants to State or other public or nonprofit private agencies or organizations for studies, experiments, and demonstrations looking toward development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons. Any grant for any such project made from an appropriation under this section for any fiscal year may include such amounts as the Surgeon General determines to be necessary for succeeding fiscal years for completion of the Federal participation in the project as approved by the Surgeon General.

(b) Payments under this section may be made in advance or by way of reimbursement, and in such installments, as may be determined by the Surgeon General; and shall be made on such conditions as the Surgeon General finds necessary to carry out the purposes of this section. Nothing in this Act shall preclude a State or community from establishing and collecting fees for personal health services which **may** be provided through programs financed from funds under this section when collection of such fees is authorized or required by State or local law.

(c) The Surgeon General, at the request of a State or other public agency, may reduce the grant to such agency under this section by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Public Health Service to such agency when such detail is made for the convenience of and at the request of such agency and for the purpose of carrying out its study, experiment, or demonstration with respect to which a grant is made under this section. The amount by which such grant is so reduced shall be available for payment of such costs by the Surgeon General, but shall, for purposes of subsection (b), be deemed to have been paid to such agency.

GRANTS FOR **[INTENSIVE VACCINATION]** IMMUNIZATION PROGRAMS

SEC. 317. (a) There are hereby authorized to be appropriated \$14,000,000 for the fiscal year ending June 30, 1963, and \$11,000,000 each for the fiscal years ending June 30, 1964, **[and]** June 30, 1965, *and each of the next three fiscal years*, to enable the Surgeon General to make grants to States and, with the approval of the State health authority, to political subdivisions or instrumentalities of the States under this section. Amounts appropriated pursuant to this section for **[the fiscal years ending June 30, 1963, and June 30, 1964]** *any fiscal year ending prior to July 1, 1968*, shall be available for making such grants during the fiscal year for which appropriated and the succeeding fiscal year. Such grants may be used to pay that portion of the cost of **[intensive community vaccination]** *immunization* programs against poliomyelitis, diphtheria, whooping cough, **[and tetanus]** *tetanus, and measles* which is reasonably attributable to (1) purchase of vaccines needed to protect children **[under the age of five years]** *of preschool age* and such additional groups of children as may be described in regulations of the Surgeon General upon his finding that they are not normally served by school vaccination pro-

grains and (2) salaries and related expenses of additional State and local health personnel needed for planning, organizational, and promotional activities in connection with such programs, including studies to determine the immunization needs of communities and the means of best meeting such needs, and personnel and related expenses needed to maintain additional epidemiologic and laboratory surveillance occasioned by such programs. *Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future.*

(b) For purposes of this section an [“intensive community vaccination”] *“immunization program”* means a program [of limited duration] which is so designed and conducted as to achieve, with the cooperation of practicing physicians, official health agencies, voluntary organizations, and volunteers, the immunization [against polio myelitis, diphtheria, whooping cough, and tetanus] *against the diseases referred to in subsection (a)* over the period of the program of all, or practically all, susceptible persons in a community, particularly children [who are under the age of five years] *of preschool age*, and which includes plans and measures looking toward the strengthening of ongoing community programs for the immunization against such diseases of infants and for maintenance of immunity in the remainder of the population. Nothing in this section shall be construed to require any State or any political subdivision or instrumentality of a State to have an [intensive community vaccination] *immunization* program which would require any person who objects to immunization to be immunized or to have any child or ward of his immunized.

(c)(1) Payments under this section may be made in advance or by way of reimbursement, in such installments, and on such terms and conditions as the Surgeon General finds necessary to carry out the purposes of this section, and the Surgeon General may, if the applicant State or other political subdivision or instrumentality so requests, purchase and furnish vaccines in lieu of making money grants for the purchase thereof.

(2) Each applicant under this section for a money grant for the purchase of vaccines, or for a grant of vaccines in lieu of a money grant, for use in connection with an [intensive community vaccination] *immunization* program shall, at the time it files its application with the Surgeon General, provide the Surgeon General with assurances satisfactory to him that it will, if it receives such a grant, furnish any physician, who practices in the area in which such program is to be carried out and makes application therefor to it, with such amounts of vaccines as are reasonably necessary in order to permit such physician during the period of such program to immunize his patients who are in the group for whose immunization such grant of money or vaccines is made.

(3) Each applicant for a grant under this section for use in connection with an [intensive community vaccination] *immunization* program shall, at the time it files its application for such grant with the Surgeon General, provide the Surgeon General with assurances

satisfactory to him that it will, if it receives such grant, furnish such other services and materials as may be necessary to carry out such program.

(d) The Surgeon General, at the request of a State or other public agency, may reduce the grant to such agency under this section by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee of the Public Health Service to such agency when such detail is made for the convenience of and at the request of such agency and for the purpose of carrying out a function for which a grant is made under this section. The amount by which such grant is so reduced shall be available for payment of such costs by the Surgeon General, but shall, for purposes of subsection (c), be deemed to have been paid to such agency.

(e) Nothing in this section shall limit or otherwise restrict the use of funds which are granted to a State or to a political subdivision of a State under title V of the Social Security Act, other provisions of this Act, or other Federal law and which are available for the purchase of vaccine or for organizing, promoting, conducting, or participating in immunization programs, from being used for such purposes in connection with programs assisted through grants under this section.



Union Calendar No. 115

89TH CONGRESS
1ST SESSION

H. R. 2986

[Report No. 249]

IN THE HOUSE OF REPRESENTATIVES

JANUARY 18, 1965

Mr. HARRIS introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

APRIL 15, 1965

Reported with amendments, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

[Omit the part struck through and insert the part printed in italic]

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Community Health
4 Services Extension Amendments of 1965".

5 IMMUNIZATION PROGRAMS

6 SEC. 2. (a) The first sentence of subsection (a) of
7 section 317 of the Public Health Service Act is amended by
8 striking out "and" before "\$11,000,000" and by inserting

1 ~~“and such sums as may be necessary for each of the next~~
2 ~~five fiscal years” immediately after “June 30, 1965,”.~~ *The*
3 *first sentence of subsection (a) of section 317 of the Public*
4 *Health Service Act is amended by striking out “and” before*
5 *“June 30, 1965” and by inserting “and each of the next*
6 *three fiscal years,” immediately after “June 30, 1965,”.* *The*
7 *second sentence of such subsection is amended by striking*
8 *out “the fiscal years ending June 30, 1963, and June 30,*
9 *1964” and inserting in lieu thereof “any fiscal year ending*
10 *prior to July 1, 1970 1968”.* *The third sentence of such*
11 *subsection is amended by striking “and tetanus” and insert-*
12 *ing in lieu thereof “tetanus, and measles”, and by striking*
13 *out “under the age of five years” and inserting in lieu thereof*
14 *“of preschool age”.*

15 (b) Subsection (a) of such section is further amended
16 by adding at the end thereof the following new sentence:
17 “Such grants may also be used to pay similar costs in con-
18 nection with immunization programs against any other dis-
19 ease of an infectious nature which the Surgeon General finds
20 represents a major public health problem in terms of high
21 mortality, morbidity, disability, or epidemic potential and
22 to be susceptible of practical elimination as a public health
23 problem through immunization with vaccines or other pre-
24 ventive agents which may become available in the future.”

25 (c) Subsection (b) of such section is amended by

1 striking out “of limited duration”, by striking out “against
 2 poliomyelitis, diphtheria, whooping cough, and tetanus” and
 3 inserting in lieu thereof “against the diseases referred to in
 4 subsection (a)”, and by striking out “who are under the
 5 age of five years” and inserting in lieu thereof “of preschool
 6 age”.

7 (d) (1) Such section is further amended by striking out
 8 “intensive community vaccination” wherever it appears in
 9 subsections (a), (b), and (c) and inserting in lieu thereof
 10 “immunization”.

11 (2) *The heading of such section is amended by striking*
 12 *out “INTENSIVE VACCINATION” and inserting in lieu thereof*
 13 *“IMMUNIZATION”.*

14 MIGRATORY WORKERS HEALTH SERVICES

15 SEC. 3. Section 310 of the Public Health Service Act
 16 is amended by striking out “the fiscal year ending June 30,
 17 1963, the fiscal year ending June 30, 1964, and the fiscal
 18 year ending June 30, 1965” and inserting in lieu thereof
 19 “each fiscal year ending prior to July 1, ~~1970~~ 1968” ; and
 20 ~~by striking out “any year” and inserting in lieu thereof “any~~
 21 ~~year ending prior to July 1, 1965”.~~

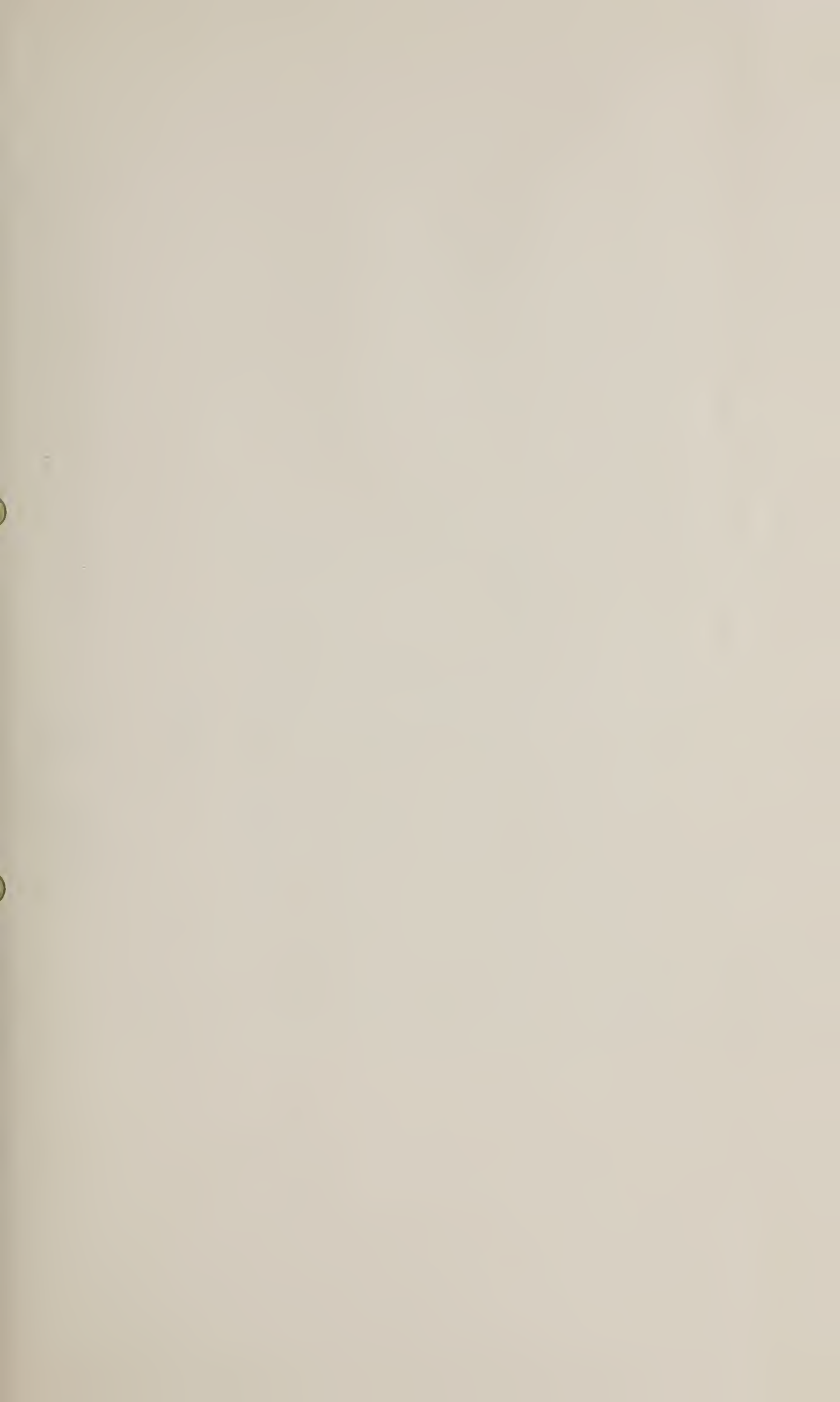
22 GENERAL PUBLIC HEALTH SERVICES

23 SEC. 4. The first sentence of subsection (c) of section
 24 314 of such Act is amended by striking out “first five fiscal

1 years ending after June 30, 1961” and inserting in lieu
2 thereof “first six fiscal years ending after June 30, 1961”.

3 SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH
4 SERVICES

5 SEC. 5. The first sentence of subsection (a) of section
6 316 of such Act is amended by striking out “first five fiscal
7 years ending after June 30, 1961” and inserting in lieu
8 thereof “first six fiscal years ending after June 30, 1961”.



89TH CONGRESS
1ST SESSION

H. R. 2986

[Report No. 249]

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

By Mr. HARRIS

JANUARY 18, 1965

Referred to the Committee on Interstate and Foreign Commerce

APRIL 15, 1965

Reported with amendments, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

Digest of CONGRESSIONAL PROCEEDINGS

OF INTEREST TO THE DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

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HIGHLIGHTS: House received conference report on second supplemental appropriation bill. House passed water pollution control bill. House committee voted to report Northwest flood disaster relief bill. House Rules Committee cleared omnibus transportation bill. Senate committee reported foreign aid authorization bill. Sen. Tower introduced and discussed bill to transfer Division of Predator and Rodent Control from Interior to USDA. Sen. McGovern introduced and discussed bill to provide assured supply of milk for assistance programs.

HOUSE

1. WATER POLLUTION. By a vote of 396 to 0, passed with amendments S. 4, the proposed Water Quality Act of 1965 (pp. 8362-8400, 8438-9). As passed the bill includes provisions as follows: Provides for the creation of a Federal Water Pollution Control Administration in HEW. Authorizes a 4-year program at an annual level of \$20 million for grants to develop projects which will demonstrate new or improved methods of controlling waste discharges from storm sewers or combined storm and sanitary sewers. Authorizes an increase in the

ceiling limitations on grants for construction of waste treatment works from \$600,000 to \$1.2 million for an individual project and from \$2.4 million to \$4.8 million for a joint project in which two or more communities participate.

2. FLOOD DISASTER RELIEF. The Public Works Committee voted to report (but did not actually report) with amendment H. R. 7303, to provide assistance to Calif., Ore., Wash., Nev., and Idaho for the reconstruction of areas damaged by recent floods and high waters. p. D331
3. FORESTRY; PUBLIC LANDS. The Interior and Insular Affairs Committee voted to report (but did not actually report) H. R. 396, to provide that until June 30, 1968, Congress shall be notified of certain proposed public land actions. p. D330
4. FLOOD CONTROL; RIVER BASINS. The Public Works Committee voted to report (but did not actually report) H. R. 6755, to authorize additional appropriations for prosecution of projects in certain comprehensive river basin plans for flood control. p. D330
5. TRANSPORTATION. The Rules Committee reported a resolution for consideration of H. R. 5401, to amend the Interstate Commerce Act so as to strengthen and improve the national transportation system. p. 8452
6. WATERSHEDS. The "Daily Digest" states that the Public Works Committee "approved four watershed projects and seven flood control resolutions." p. D331

7. HEALTH. The Rules Committee reported resolutions for consideration of H. R. 2984, to amend the Public Health Service Act provisions for construction of health research facilities, and H. R. 2986, to extend and amend certain provisions of the Public Health Service Act relating to community health services. p. 8452

8. APPROPRIATIONS. Permission was granted the Appropriations Committee to file by midnight, Thurs., Apr. 29, a report on the Departments of Labor and HEW and related agencies appropriation bill for 1966. p. 8357

9. FOREIGN AID. Rep. Erlenborn criticized foreign aid expenditures abroad and cited reports of GAO in support of his position. pp. 8408-9

10. FOREIGN TRADE. Rep. Saylor inserted a "set of documents illustrating the policies adopted by other countries to assure their own industries and workers - at the exclusion of foreigners - of obtaining public works contracts." pp. 8426-32

SENATE

11. PESTICIDES. The Commerce Committee reported with amendment S. 1623, to authorize a continued study by the Department of the Interior of the effects of insecticides, herbicides, fungicides, and other pesticides upon fish and wildlife (S. Rept. 169). p. 8456
12. FOREIGN AID. The Foreign Relations Committee reported an original bill, S. 1837, to amend the Foreign Assistance Act of 1961 (S. Rept. 170). p. 8456

CONSIDERATION OF H.R. 2986

APRIL 28, 1935.—Referred to the House Calendar and ordered to be printed

Mr. DELANEY, from the Committee on Rules, submitted the following

R E P O R T

[To accompany H. Res. 357]

The Committee on Rules, having had under consideration House Resolution 357, report the same to the House with the recommendation that the resolution do pass.



House Calendar No. 59

89TH CONGRESS
1ST SESSION

H. RES. 357

[Report No. 268]

IN THE HOUSE OF REPRESENTATIVES

APRIL 28, 1965

Mr. DELANEY, from the Committee on Rules, reported the following resolution; which was referred to the House Calendar and ordered to be printed

RESOLUTION

1 *Resolved*, That upon the adoption of this resolution it
2 shall be in order to move that the House resolve itself into
3 the Committee of the Whole House on the State of the
4 Union for the consideration of the bill (H.R. 2986) to
5 extend and otherwise amend certain expiring provisions of
6 the Public Health Service Act relating to community health
7 services, and for other purposes. After general debate,
8 which shall be confined to the bill and shall continue not
9 to exceed two hours, to be equally divided and controlled
10 by the chairman and ranking minority member of the
11 Committee on Interstate and Foreign Commerce, the bill
12 shall be read for amendment under the five-minute rule.

1 At the conclusion of the consideration of the bill for amend-
2 ment, the Committee shall rise and report the bill to the
3 House with such amendments as may have been adopted,
4 and the previous question shall be considered as ordered on
5 the bill and amendments thereto to final passage without
6 intervening motion except one motion to recommit.

89TH CONGRESS
1ST SESSION

H. RES. 357

House Calendar No. 59

[Report No. 268]

RESOLUTION

Providing for consideration of H.R. 2986, a bill
to extend and otherwise amend certain ex-
piring provisions of the Public Health Serv-
ice Act relating to community health serv-
ices, and for other purposes.

By Mr. DELANEY

APRIL 28, 1965

Referred to the House Calendar and ordered to be
printed

May 3, 1965

Rep. Ottinger urged action on his bill to provide for the establishment of the Hudson Highlands National Scenic Riverway in N. Y. pp. 8869-71

13. HEALTH. Passed with amendment S. 510, to extend and amend certain expiring provisions of the Public Health Service Act relating to community health services, after substituting the language of a similar bill, H. R. 2986, which was passed earlier. H. R. 2986 was tabled. House conferees were appointed. pp. 8822-~~23~~ *8826-33*
14. WATERSHEDS. The Public Works committee approved work plans for the following watersheds: Badger Creek (supplemental), Iowa; Ketchepedrakee Creek, Ala.; Twin-Rush Creek, Ind.; and Walter's Creek, Iowa. pp. 8807-8
15. COTTON. Rep. Dorn inserted a S. C. State Legislature resolution urging extension of the "one-price cotton program for the seasons of 1966 and 1967." p. 8842
16. WATER CONSERVATION; ELECTRIFICATION. Rep. Hosmer stated that the proposed construction of dams above and below the Grand Canyon would not cause "the flooding out of the Grand Canyon," and that this is a "necessary...project for the vital purpose of relieving arid conditions" in Ariz., Nev. and Calif. pp. 8856-7
Rep. Bolton inserted an article, "Attack on Grand Canyon," stating that "Grand Canyon...is in imminent danger, threatened by two huge unnecessary power dams." pp. 8866-7
17. FOREIGN TRADE. Rep. Saylor criticized our foreign spending policies and inserted an article. "European Free Trade Association." pp. 8858-62
18. DAYLIGHT SAVING TIME. Rep. Fraser spoke of the confusion caused by daylight saving time in Minn. and urged support of his bill to provide a uniform period for daylight saving time. p. 8875
19. FIRE ANT. Rep. O'Neal, Ga., commended and inserted a report, "A Review of the Problem of the Imported Fire Ant." pp. 8876-81
20. RECLAMATION. A subcommittee of the Interior and Insular Affairs Committee voted to report to the full committee with amendment H. R. 6032, to amend the Act authorizing the Mann Creek Federal Reclamation project, Idaho, in order to increase the amount authorized to be appropriated for such project (Act of August 16, 1962; 76 Stat. 388). p. D346
21. FEDERAL DEBT. Rep. Martin, Ala., stated that "we are still piling up huge deficits which endanger our economy," and inserted an article, "Over \$30 Billion in the Red." pp. 8838-9
22. LEGISLATIVE PROGRAM. The "Daily Digest" states that on Tues., May 4, the House will consider H. R. 7765, the Labor-HEW appropriation bill. p. D346

ITEMS IN APPENDIX

23. OPINION POLL. Rep. Baldwin inserted the results of a poll which includes questions on tobacco price supports, and the sale of surplus commodities to Communist countries. pp. A2084-5

24. SOCIAL SECURITY; HEALTH. Rep. Hall inserted "an excellent and critical analysis" of the medicare bill as passed by the House. pp. A2085-6
25. FARM PROGRAM. Rep. Findley inserted an article written by a farmer's wife, "Get the Government Off the Farm." pp. A2087-9
26. NATURAL RESOURCES; FORESTRY. Rep. Race inserted Sen. Nelson's press release announcing that the Senate Appropriations Committee had approved requests to expand the Forest Products Laboratory at Madison, Wisc., and funds to buy the Sylvania tract of land to be developed as a recreational area by Forest Service. pp. A2082-3
27. FOREIGN AID. Rep. Fraser inserted an excerpt from an AID summary presentation to Congress on the proposed mutual defense and development program, "Aid in Perspective." pp. A2099-2100
28. ECONOMIC DEVELOPMENT. Extension of remarks of Rep. Fraser inserting an address urging increases in commitments to the economic development of less-developed areas and stating that the "...the agricultural sector has been sadly lagging behind." pp. A2109-11
29. ELECTRIFICATION. Rep. Moss inserted an article, "Electricity is Key to Democracy's Salvation." p. A2114
30. WATER POLLUTION. Extension of remarks of Rep. Hanley expressing approval of the water pollution control bill as passed by the House and inserting a series of articles on major pollution problems. pp. A2114-7
31. FOREIGN TRADE. Extension of remarks of Rep. Bandstra favoring freer world trade and stating that "by lowering barriers to commercial transactions between countries, we also reduce the barriers to the free exchange of ideas." pp. A2126-7

BILLS INTRODUCED

32. HOUSING. H. R. 7754 by Rep. Schmidhauser, to amend certain laws relating to housing in order to assist in the provision of decent, safe, and sanitary housing for low-income families in urban and rural areas, to provide standard for determining just compensation in eminent domain proceedings. (Int. April 29, 1965)
33. RECLAMATION. H. R. 7785 by Rep. Hagen, Calif., to amend the Small Reclamation Projects Act of 1956; to Interior and Insular Affairs Committee.
H. R. 7786 by Rep. Hagen, Calif., to amend the act of July 4, 1955, as amended, relating to the construction of irrigation distribution systems; to Interior and Insular Affairs Committee.
34. PERSONNEL. H. R. 7807 by Rep. Pepper, to amend the Civil Service Retirement Act as amended to provide for the recomputation of annuities of retired employees who are receiving reduced annuities because they had not attained the age of 60 years prior to retirement; to Post Office and Civil Service Committee.
H. R. 7817 by Rep. Schmidhauser, to prohibit nepotism in Government employment; to Post Office and Civil Service Committee.

this bill would provide no material increase because of the relatively small number of employees to whom this section applies.

I strongly support this bill and urge my colleagues to support it. I am happy to report to you that this bill received the unanimous approval of our committee.

Mr. CORBETT. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I agree entirely with the gentleman from Pennsylvania who has just concluded. It was my pleasure in 1954 to be the manager of this life insurance program when it first came to the floor of the House. Since that time we have seen the program put into operation and become one of the major fringe benefits of Government employees in this country.

Presently we are approaching a time when the first important correction is needed in the program. That correction as the gentleman just outlined is to raise first the amount of maximum insurance which can be purchased by an employee and, secondly, if possible to have the Government's participation in the premiums increased.

I was very happy that it was pointed out that private business is more and more paying from 50 to 100 percent of the life insurance premiums of their employees. I think the Federal Government has lagged very greatly in only paying one-third of the cost. To suggest seriously that the Government employee's payments be increased while the Government's payment be held at the same figures that they are now—12½ cents per thousand for a biweekly pay period is absolutely going the wrong way.

I believe it should also be pointed out that the committee, by acting now rather than waiting for the President's Cabinet Committee to make a finding, is doing exactly the right thing. The President's Cabinet Committee is not scheduled to report until December of this calendar year. Under this arrangement legislation of this nature would not reach the floor probably until March, April, or May of 1966. In the meantime, many, many employees would have died or retired and would have lost the benefits contemplated under this bill.

Likewise, while the fund is still in good shape, we are approaching danger points and greater amounts of money should go into the fund. The Government should act now.

In any event, we all know that committees and commissions have sometimes been created for the exact purpose of delay. We know even when that was not the purpose, that has often been the result.

In making it permissive for the administration to increase the Government's payments if the President's Cabinet Committee finds that to be wise, it will not be necessary to come to Congress for permission—they will have it already—and the recommendations can be put into effect promptly, instead of waiting for the slow legislative process to be concluded.

Mr. Speaker, I strongly urge that this legislation be passed. It is timely. It is in order. It is sound. I believe it will make its contribution toward maintaining a good life insurance program, which will do that much more to make employment with our Federal Government that much more attractive to good, capable employees.

(Mr. CORBETT asked and was given permission to revise and extend his remarks.)

Mr. CORBETT. Mr. Speaker, I yield such time as he may consume to the gentleman from Nebraska, the ranking minority member of the subcommittee.

Mr. CUNNINGHAM. Mr. Speaker, I wish to compliment my distinguished colleague on the committee, the gentleman from Pennsylvania [Mr. GREEN], for a very clear statement as to the purpose of the bill. I also commend the statement made by the gentleman from Pennsylvania [Mr. CORBETT], the ranking minority member of the full committee.

I was a member of the Committee on Post Office and Civil Service when this piece of legislation was first enacted, as well as when the Federal Employees Health Benefits Act passed. These two programs have served all the employees and Members of the House of Representatives and the other body very well.

I might add that this bill does not apply only to Federal workers in the various agencies, but will afford the Members of Congress an opportunity to increase their life insurance under this program from \$20,000 to \$30,000.

Mr. Speaker, I rise in full support of this bill. As the gentleman from Pennsylvania said, I am the ranking minority member on this subcommittee. This bill was passed unanimously by the subcommittee and by the full committee.

Mr. OLSEN of Montana. Mr. Speaker, I rise in support of H.R. 6926.

First of all, I should like to commend the Subcommittee on Retirement, Insurance, and Health Benefits for developing this important legislation, and particularly to congratulate the gentleman from Pennsylvania [Mr. GREEN] for his very thorough analysis and explanation of the bill.

Mr. Speaker, the establishment of policy with respect to both salaries and fringe benefits of Federal employees is, and must be exclusively in the province of the Congress. The Congress has laid down the firm policy of comparability of Federal civilian salaries with those in private enterprise, and the same principle certainly should be applied to fringe benefits, including the Federal employees' life insurance program.

We have made significant progress toward salary comparability and there is no reason whatever for the Government's participation in our employees' life insurance program to lag behind similar programs for employees in enlightened private enterprise. Mediocrity will not suffice; our Federal program should be at least on a par with the best in private industry.

It was my privilege, thorough the courtesy of our Subcommittee on Retirement,

Insurance, and Health Benefits, to attend public hearings on this legislation. In my judgment, the evident need for this legislation was clearly demonstrated when the Chairman of the Civil Service Commission testified, in response to questioning, that many private corporations pay at least half, and some pay all, of the costs of employee life insurance programs. The trend in private industry, according to testimony based on AFL-CIO data sources, is well beyond the 50-percent level for employers' contributions.

The Bureau of Labor Statistics in the Department of Labor has conducted two studies which further support the need for H.R. 6926. The first, printed in Bulletin No. 1330, is entitled: "A Digest of 100 Selected Health and Insurance Plans Under Collective Bargaining, Winter 1961-62." It was brought further up to date by a supplemental study of 50 plans in 1963.

The first such study disclosed that approximately 40 of the 100 corporations paid the entire cost of their employees' life insurance plans, and all but a few paid at least half of the cost. To name a few, the American Sugar Refining Co., Armstrong Cork Co., Swift & Co., Armour & Co., Campbell Soup Co., Liggett & Myers Tobacco Co., Distillery Industry, Clothing Industry, Continental Can, Inc., Bethlehem Steel Co., Owens-Illinois Glass Co., and the Firestone Tire & Rubber Co., pay the full cost. Incidentally, they also pay the full cost of their employees' health insurance plans. Some even permit employees to carry life insurance equal to double the amount of their earnings.

Mr. Speaker, this bill represents the first major revision of the Federal Employees' Group Life Insurance Act of 1954 since it was enacted nearly 11 years ago. The record is clear that our program has fallen seriously behind the trend in private industry. Enactment of H.R. 6926 will be a step in the right direction toward closing the gap, and I earnestly recommend its approval by the House.

(Mr. OLSEN of Montana asked and was given permission to revise and extend his remarks.)

The SPEAKER pro tempore. The question is on the motion of the gentleman from Montana that the House suspend the rules and pass the bill H.R. 6926.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

JURY COMMISSIONERS FOR U.S. DISTRICT COURTS

Mr. ASHMORE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5640) to provide for a jury commission for each U.S. district court, to regulate its compensation, to prescribe its duties, and for other purposes.

The Clerk read as follows:

H.R. 5640

A bill to provide for a jury commission for each United States district court, to regulate its compensation, to prescribe its duties, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 1864 of title 28 of the United States Code is amended to read as follows:

"§ 1864. Jury commission: Duties, compensation, and methods of selecting and drawing jurors

"(a) APPOINTMENT.—A jury commission shall be established in each judicial district, consisting of the clerk of the court and one or more jury commissioners, appointed by the district court. The jury commissioner shall be a citizen of the United States of good character residing in the district of appointment who, at the time of his appointment, shall not be a member of the same political party as the clerk of the court or a duly qualified deputy clerk acting for the clerk. If more than one jury commissioner is appointed, each may be designated to serve in one or more of the places where court is held, and the clerk and the jury commissioner so designated shall constitute the jury commission for that part of the district. In the event that a jury commissioner is unable for any reason to perform his duties, another jury commissioner may be appointed, as provided herein, to act in his place until he is able to resume his duties.

"Jury commissioners shall be appointed to serve on a part-time or full-time basis. If in the opinion of the court the efficient operation of the jury system requires the services of a full-time jury commissioner, the court may, with the approval of the Judicial Conference of the United States, appoint one or more full-time jury commissioners.

"(b) DUTIES.—In the performance of all its duties the jury commission shall act under the direction and supervision of the chief judge of the district.

"The sources of the names and the methods to be used by the jury commission in selecting the names of persons who may be called for grand or petit jury service shall be as directed by the chief judge. The procedures employed by the jury commission in selecting the names of qualified persons to be placed in the jury box, wheel, or similar device, shall not systematically or deliberately exclude any group from the jury panel on account of race, sex, political, or religious affiliations, or economic or social status. In determining whether persons are qualified as jurors under section 1861 of this title, the jury commission shall use questionnaires and such other means as the chief judge may deem appropriate, including the administering of oaths.

"The names of jurors shall be publicly drawn by chance from a jury box, wheel, or similar device, which contains the commencement of each drawing the names of not less than three hundred qualified persons selected by the jury commission in accordance with the provisions of this subsection.

"The jury commission shall keep records of the names of persons placed in the jury box, wheel, or similar device, the questionnaires returned by said persons, the names of the persons who are selected for jury service, the dates of service, and such other appropriate records as the chief judge may direct, all for a period of not less than two years. With the approval of the chief judge, the jury commission may designate deputy clerks and other employees in the office of the clerk of the court to assist the commission in the performance of its duties and to perform under its direction such of the detailed duties of the commission as in the opinion of the chief judge can be assigned to them.

"(c) COMPENSATION.—Each jury commissioner appointed on a part-time basis shall be compensated for his services at the rate of \$10 per day for each day in which he actually and necessarily is engaged in the performance of his official duties, to be paid upon certificate of the chief judge of the district.

"Each jury commissioner appointed on a full-time basis shall receive a salary to be fixed from time to time by the Judicial Conference of the United States at a rate which in the opinion of the Judicial Conference corresponds to that provided by the Classification Act of 1949, as amended, for positions in the executive branch with comparable responsibilities.

"Each jury commissioner shall receive his traveling and subsistence expenses within the limitations prescribed for clerks of district courts while absent from his designated post of duty on official business.

"(d) Any of the powers or duties conferred upon the chief judge under this section may be delegated by him to another judge of the district: *Provided, however,* That where part of a district by agreement or order of court is assigned to one particular judge and he customarily holds court there, as to such part of the district he shall perform the functions and fulfill the duties conferred upon the chief judge in this section.

"(e) This section shall not apply to the District of Columbia."

Sec. 2. Section 1865 of such title is amended by striking out the words "and may appoint a jury commissioner for each such place" in the second sentence of subsection (a) thereof and inserting a period after the word "district" in such sentence.

Sec. 3. Each jury commissioner holding office on the effective date of this Act shall continue in office until his successor is duly appointed and qualified.

Sec. 4. There are hereby authorized to be appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary to carry the provisions of this Act into effect.

Sec. 5. The provisions of this Act shall take effect ninety days after the date of approval thereof: *Provided, however,* That no grand or petit jury sworn prior to the effective date of this Act nor any person called or summoned for jury service, or whose name is on a jury list or has been placed in a box, wheel, or similar device, prior to that date, shall be ineligible to serve if the procedure by which the jury or the individual juror was selected, called, summoned, or by which his name was listed or placed in a box, wheel, or similar device, was in compliance with the law in effect at the time of such action.

Sec. 6. (a) The table of sections at the head of chapter 121 of title 28 of the United States Code is amended by amending items 1864 and 1865 to read as follows:

"1864. Jury commission; duties, compensation, and methods of selecting and drawing jurors."

"1865. Apportionment within district."

(b) The catchline at the beginning of section 1865 of title 28 of the United States Code is amended to read as follows:

"§ 1865. Apportionment within district."

The SPEAKER pro tempore (Mr. ALBERT). Is a second demanded?

Mr. KING of New York. Mr. Speaker, I demand a second.

The SPEAKER pro tempore. Without objection, a second will be considered as ordered.

There was no objection.

Mr. ASHMORE. Mr. Speaker, the purpose of this bill is to revise the existing language of title 28, United States Code, section 1864. It would improve

and strengthen the operation of jury commissions for each judicial district of the United States and would also impose a greater responsibility, I might say, upon the chief judge of each district court to supervise the performance of the duties of the jury commission.

Mr. Speaker, I have no requests for time and yield back the balance of my time, because I know of no questions on this matter.

(Mr. KING of New York asked and was given permission to revise and extend his remarks.)

Mr. KING of New York. Mr. Speaker, I join with my colleague from South Carolina and urge my colleagues to support this bill.

Mr. Speaker, I join with my distinguished colleague from South Carolina in supporting the bill H.R. 5640 concerning jury commissions for each U.S. district court. This bill was considered by the subcommittee of which the gentleman from South Carolina is the chairman and of which I am privileged to be a member. The bill was unanimously recommended by the subcommittee and the full committee and has as its basic purpose the revision of the existing language of section 1864 of title 28 of the United States Code, so as to improve and strengthen the work of jury commissions in each judicial district. The bill further expressly provides that the chief judge of the district shall direct and supervise the jury commission in the performance of its duties. The language proposed in the bill clearly defines the duties of the commission and further provides for the appointment of commissioners and their compensation.

The testimony before the subcommittee established that in some instances the lack of supervision of those charged with the initial selection of persons to be called for jury service has resulted in challenges of the juries ultimately selected for trial of cases in the U.S. district courts. When it is considered that the jury system is basic in our system of law, I feel that it is self-evident that every effort should be made to improve and strengthen procedures associated with the selection of persons who ultimately may be called upon to serve as jurors in the trial of cases in the Federal courts. I feel the provisions of H.R. 5640 have been carefully drafted to further this purpose.

Mr. Speaker, I have no further requests for time.

The SPEAKER pro tempore. The question is on the motion of the gentleman from South Carolina that the House suspend the rules and pass the bill H.R. 5640.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965

Mr. DELANEY. Mr. Speaker, I call up House Resolution 357 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 357

Resolved, That upon the adoption of this resolution it shall be in order to move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2986) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes. After general debate, which shall be confined to the bill and shall continue not to exceed two hours, to be equally divided and controlled by the chairman and ranking minority member of the Committee on Interstate and Foreign Commerce, the bill shall be read for amendment under the five-minute rule. At the conclusion of the consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit.

Mr. DELANEY. Mr. Speaker, I yield one-half of my time to the gentleman from California [Mr. SMITH]. I now yield myself such time as I may consume.

Mr. Speaker, House Resolution 357 provides for consideration of H.R. 2986, a bill to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes. The resolution provides an open rule with 2 hours of general debate.

H.R. 2986 extends four current programs carried out under the Public Health Service Act relating to health services.

It extends the duration of the current immunization program for an additional 3 years and extends the coverage of the program to include assistance in immunization programs against measles and other diseases presenting a major public health problem.

The bill also extends for an additional 3 years the current program under health services provided to domestic agricultural migratory workers.

The current program authorizing \$50 million annually for grants to the States for health services under section 314(c) of the Public Health Service Act is extended for an additional year, and the program of special project grants for community health services authorizing appropriations up to \$10 million annually is also extended for an additional year. Both of these latter programs are under review by the Public Health Service and the Association of State and Territorial Health Officers, and the State and territorial mental health authorities.

Mr. Speaker, I urge the adoption of H. Res. 357.

Mr. SMITH of California. Mr. Speaker, I yield myself such time as I may consume.

(Mr. SMITH of California asked and was given permission to revise and extend his remarks.)

Mr. SMITH of California. Mr. Speaker, as stated by the distinguished gentleman from New York House Resolution 357 provides an open rule with 2 hours

of general debate for the consideration of the bill, H.R. 2986. H.R. 2986 will extend the Community Health Services. It is a very fine bill. I know of no objection to it and I know of no objection to the rule.

(Mr. SMITH of California asked and was given permission to speak out of order and to revise and extend his remarks.)

Mr. SMITH of California. Mr. Speaker, I am compelled to speak out on a matter of grave concern, not only to the citizens of the great State of California, but to all people of this Republic. This urge is prompted by a deep and abiding love of our Nation and a reminder that 30 days hence, on May 30, Americans will be memorializing those who so loved their country that they laid down their lives in its defense.

How callous, how unfeeling we would be if we labeled as naught the sacrifice of these martyrs of freedom. Yet, today we are being asked—no, it is being demanded—that we abandon our great heritage as protectors of freedom and allow the forces of communism to engulf the world. We are being urged to follow a course that has been mapped by practitioners of deceit and treachery.

I, for one, will not be coerced by means repugnant to our democratic processes.

DIRTY WAR OF IMPERIALIST AGGRESSION

During the last several months, the international event which has most occupied the attention of the Communist Party, U.S.A., and the Communist-inspired youth group, the WEB Du Bois Clubs of America, has been the war in Vietnam. Following long-established practice of supporting Communist causes wherever they exist throughout the world, the Communist Party, U.S.A., justifies and supports with propaganda the Communist Vietcong. At the same time, the party criticizes with vehemence and protests against U.S. foreign policy in Vietnam.

Deliberately ignoring the real issues of Communist invasion, Communist terror, and Communist insurgency in Vietnam, the Communist Party, U.S.A., accuses the United States of engaging in a "dirty war of imperialist aggression." To implement its steady and mounting propaganda attack against the policy of the U.S. Government in Vietnam, the Communist Party gives its full support to all mass actions such as protest demonstrations.

It is recognized, of course, that other individuals who are not members of the Communist Party or its front groups have participated in protest demonstrations against U.S. policy in Vietnam. While most individuals who have taken part in demonstrations of this type were not directly influenced by the Communist Party the Communists have endorsed and supported any group which organizes such a demonstration. This policy was established almost a year ago when Jack Stachel, member of the party's national committee, proposed the formation of a united front of Communists, other leftist groups, trade unions, peace organizations, Negro organizations, and churches

to promote a campaign in opposition to U.S. policy in southeast Asia.

PARTY DIRECTIVES AND DISCUSSIONS

Let us take a look at the development of this Communist campaign against U.S. policy in Vietnam.

During March 1964, a directive entitled "The United States and South Vietnam Developments" was sent out from the Communist Party's national headquarters in New York City to all its districts. The situation in southeast Asia was described in this directive as an even greater threat to peace than Cuba or Berlin. Party members were urged to send telegrams to President Johnson protesting American "military aggression" in South Vietnam, to place advertisements in newspapers throughout the country, to organize protest meetings and picket lines, and to enlist the support of non-Communist groups in these activities.

Vietnam was the principal topic of discussion at a meeting of the top Communist Party leaders in June 1964. At this meeting, Jack Stachel spoke up again and warned against elements in the United States who favor enlarging the war, argued that the Vietnam situation could not be settled by military force alone, and stressed that Communist China must be a participant in any negotiations. Stachel also proposed that the Communist Party, U.S.A., take the position that what is at issue in Vietnam is not U.S. prevention of Communist domination, but the right of all nations in southeast Asia to manage their own internal affairs. As a further suggestion for the party's campaign against U.S. policy in Vietnam, Stachel relied on a typical Communist tactic when he urged adoption of the slogan, "Bring the boys home."

The party then called upon Margrit Pittman to prepare a discussion outline on the topic "Vietnam and Peace." A longtime member of the Communist Party, Margrit Pittman was in the Soviet Union from 1959 to 1962. During these years, her husband, John Pittman, was the Moscow correspondent for the Communist newspaper, the Worker.

In her outline, Mrs. Pittman characterized the war in South Vietnam as a war of aggression by U.S. "imperialism" designed to expand American influence in southeast Asia and to crush the Vietnamese fight for freedom. The Vietcong insurgents, however, were said to be fighting a war of national liberation whose goal is peace through negotiations leading to the eventual reunification of North and South Vietnam. Pittman used this outline to urge telegrams, letters, resolutions, meetings, marches, and other forms of demonstrations to demand U.S. withdrawal from South Vietnam.

CAMPAIGN MOVES INTO HIGH GEAR

The incident which moved the Communist campaign into high gear was the action in the Gulf of Tonkin in early August 1964. The Communist Party, U.S.A., quickly came to the support of the North Vietnamese Communists and characteristically criticized U.S. foreign policy when American aircraft attacked

selected targets in North Vietnam following torpedo-boat attacks against our destroyers in the Gulf of Tonkin. Speaking at a meeting of the party's Southern California District, District Chairman Dorothy Healey called this retaliatory action against North Vietnam "dirty aggression" and suggested that 50,000 letters be sent to President Johnson to protest the U.S. air attack on North Vietnam.

As Mrs. Healey was speaking in California, the party's national headquarters was issuing a press release which condemned the retaliatory strike against North Vietnam and charged that U.S. warplanes had brought death to innocent people. The party claimed that the air raid on North Vietnam was an expansion of the war in the direction of the policy of brinkmanship demanded by Barry Goldwater. The press release exhorted everyone in the United States "to speak out for peace" through petitions, letters, and telegrams to be sent to President Johnson, Senators, and Congressmen. These messages were to urge negotiation and the settlement of all issues in Vietnam through the existing machinery of the 14-power Geneva Conference and the United Nations.

BRINGING PRESSURE TO BEAR

In a letter dated August 19, 1964, addressed to all Communist Party districts, the party's national organization department stated that it was obvious that the danger of expanding the war in southeast Asia remained high and that this and similar foreign policy issues would be prominent in the 1964 presidential election campaign. Party members were urged, because of the role of U.S. imperialism in southeast Asia, to use even greater initiative to stimulate pressure for a negotiated settlement and the convening of a 14-nation conference concerning Vietnam.

At a meeting of top party officials in November 1964, Arnold Johnson, the party's public relations director, reported to his comrades on the situation in Vietnam. Johnson urged that the party utilize the many organizations and "groupings" which, he claimed, were bringing pressure on the U.S. Government to end the war in Vietnam.

Johnson also suggested that the party prepare, by the end of November, a definitive document on Vietnam and distribute 50,000 copies of this document. Such a document was prepared and distributed to all the party's districts with instructions that it be given wide circulation.

Johnson further proposed that the party strive to organize a conference to be held in Washington, D.C., which would represent the totality of American opinion on Vietnam and would attempt to bring about a change in U.S. policy in Vietnam.

During another meeting of leading functionaries of the Communist Party held in late November 1964, Johnson again stressed that it was necessary for the Communist Party, U.S.A., to fight against extension of the war in Vietnam. He recommended that a memorandum on the party's position be sent

to all of its districts. The key point in the memorandum would be the demand for peace and an end to the war in Vietnam. Johnson also suggested a petition and postcard campaign against the war in Vietnam.

Following through on Johnson's proposals, the party's national organization department sent an avalanche of instructions to party districts pertaining to activities designed to achieve Communist objectives in South Vietnam. Party districts were told in late November, that a demand for peace was a key point in the election mandate given to President Johnson and that any implementation of that demand called for an end to the war in South Vietnam.

PEACE ON EARTH

The party's district leaders were instructed in late November to organize activities in the trade union movement, in youth organizations, and in religious organizations until peace was achieved. The party directive pointed out that this was the time of year when church and other organizations talked about peace on earth, but the "key test" would be what they said about peace in Vietnam.

In a directive issued in December, the national organization department warned party districts that every passing event made it more urgent that all sections of the population speak out "to end the war in South Vietnam." All districts were urged to make special efforts for mass activities and expressions of peace during the weekend of December 19 and 20, 1964. This directive also called attention to an enclosed leaflet which urged the reader to "join in an appeal to the conscience of America to end the war in Vietnam."

AIR STRIKES CONDEMNED

Following precedent set during the Gulf of Tonkin confrontation last August, the Communist Party was quick to give verbal support to North Vietnam and to condemn the U.S. foreign policy after a retaliatory air bombardment of North Vietnamese military targets on February 7, 1965. These air strikes followed Vietcong attacks against U.S. bases in South Vietnam.

Within minutes after the air attacks were announced, the party's general secretary, Gus Hall, who refers to himself as the leading spokesman for the Communist Party of the United States, was ready with another press release. Hall termed the American air strike as "the gravest threat to world peace since the Cuban crisis" of 1962. In his statement, Hall bitterly condemned the air strike as "an act of brutal aggression which horrifies the world." Nothing was said, of course, about the Vietcong mortar attacks.

Hall did repeat the by now familiar exhortation to the people of the United States to demand that this country withdraw all its troops from South Vietnam. He went on to say: "A policy to escalate the war can only lead to disaster. It will intimidate no one. It will bring an even more humiliating defeat or a world nuclear war. The American people must speak out loud and clear."

All the familiar Communist tactics

were again brought into play, such as a telegram campaign launched immediately by the Communist Party in an effort to pressure the White House. On the night of February 7, 1965, for example, a party conference was being held in Chicago. The proceedings were interrupted and blank telegram forms were distributed. Each of the assembled comrades was instructed to write and sign an individual telegram to President Johnson condemning the air strike. These telegrams were then sent to the White House.

In a February 9, 1965, memorandum to all districts from the national organization department, it was stated that the major point on the agenda for all the American people was obviously to bring a halt to the war in South Vietnam, to demand an end to all actions of aggression against the North Vietnam, to insist that all military personnel and forces of the United States be withdrawn from South Vietnam, and to insure that the Vietnamese be given an opportunity to determine their own destiny and to exercise their right of self-determination. This memorandum then claimed that thousands of telegrams were being sent to the President in protest against his authorization of the "brazen act of aggression" against North Vietnam.

At a meeting of party officials in mid-February, 1965, Robert Thompson, organizer of the party's New York District, stated that attempts should be made to get trade-union spokesmen to speak out publicly against the role of the United States in Vietnam. Communist Party, U.S.A., Secretariat member Gilbert Green said the situation in Vietnam had demonstrated that the Chinese Communists were not warmongers, because they had acted responsibly under great provocation. Communist Party, U.S.A., National Labor Secretary Carl Winter claimed that there was mass pressure for peace in Vietnam and President Johnson recognized this. In Winter's opinion, the "unique contribution" made by the Communist Party in the 1964 presidential election campaign was the conclusion that the people should never put their trust in President Johnson but should exert continuous pressure to obtain their goals.

COMMUNIST SPEAKERS ON COLLEGE CAMPUSES

The devious hand of the Communists appeared on the turbulent campus of the University of California at Berkeley, Calif., which has been disrupted almost constantly with "student demonstrations" during the current school year. On February 8, 1965, there was a rally of approximately 1,300 students at this campus for the purpose of protesting what was described as U.S. intervention in Vietnam. Communist Party National Committeeman Herbert Aptheker, appearing as director of the Institute for Marxist Studies, a Communist front, was one of the speakers.

Aptheker asserted that the U.S. Government was engaged in a classic imperialistic war in South Vietnam. He described the February 7, 1965, American bombing mission into North Vietnam as "not retaliatory, but aggressive and barbarous." The Vietcong was characterized by Aptheker as a national

liberation movement front embraced by the people of Vietnam. Nothing else could explain, Aptheker concluded, the success of the Vietcong against the greatest military power in the world.

In recent months, Aptheker and other Communist spokesmen have appeared at a number of colleges and universities throughout the country where they have bitterly attacked U.S. policy in Vietnam. They have indicated the United States as an aggressor interfering in the internal affairs of other nations. They contend that President Johnson could prove the sincerity of his advocacy of peace if he would seek, through negotiation, a peaceful solution to the situation in Vietnam. To them, of course, a peaceful solution would mean United States withdrawal.

The appearance of Communist speakers on college campuses is part of the Communist Party's program to propagandize young students under the guise of academic freedom. Since 1961, Communist Party luminaries have made an average of 50 campus appearances a year.

WAR ISOLATING UNITED STATES

Gut Hall held a press conference at the party's national headquarters on February 25, 1965, as a result of the new indictment of the Communist Party, U.S.A., for violation of the Internal Security Act of 1950. Hall termed the indictment an attempt to create hysteria and a national emergency for the purpose of silencing all opposition to the conduct of an unpopular, undeclared and, therefore, unconstitutional and unjust war of aggression in South Vietnam. Continuing, Hall said that the policies of aggression in South Vietnam were isolating the United States from all those who were for peace, and this "political prosecution" of the Communist Party further isolated the United States from all those who were for democracy.

Communist Party leaders and rank-and-file members have participated in demonstrations and other activities designed to carry out party directives. A recent and striking example of Communist participation in a demonstration was the April 17 march on Washington to end the war in Vietnam. A Communist Party directive, which was sent to all Communist Party districts in March 1965, described the contemplated march as the "biggest single action calling for an end to the war in Vietnam."

On March 30, 1965, Herbert Aptheker spoke to some 200 persons in New York City and attacked U.S. policy in Vietnam. He stated that this country was using Vietnam as a testing ground for new weapons, was exploiting the people and resources of Vietnam, and was continuing the war for its imperialistic designs. He urged those in this audience to write letters to their Senators and to President Johnson for the purpose of showing their indignation over U.S. policy and asking for U.S. withdrawal from Vietnam. Aptheker said that he would participate in the April 17 march on Washington and urged young people in his audience to do likewise.

Aptheker spoke again at a "teach-in" which was held at City College of New York on April 13 and 14. Before a crowd

which varied from 400 to 600 Aptheker severely criticized the policies of the United States in Vietnam.

STUDENT MARCH ON WASHINGTON

The planned student march on Washington was held on April 17, 1965. It was the largest single demonstration held to date to protest U.S. action in Vietnam. Some 15,000 persons participated in the demonstration. While the march was not Communist initiated, dominated, or controlled, Communist Party members from throughout the Nation participated in this demonstration. Among the leading Communist participants were Arnold Johnson, Michael Zagarell, and George Meyers. Johnson is the party's public relations director; Zagarell is the party's national youth director; and Meyers is in charge of the party's southern region.

In addition to members of the Communist Party and the Du Bois Clubs who participated in the march were representatives of such Communist splinter groups as the Socialist Workers Party, Young Socialist Alliance, Workers World Party, Youth Against War and Fascism, Progressive Labor Movement, and May 2 Movement.

The greatest number of individuals with subversive backgrounds who participated in the march came from New York City, including 78 individuals who were identified as Communist Party members or sympathizers. There were also participants with subversive backgrounds from such other major cities as Baltimore, Boston, Buffalo, Cleveland, Seattle, and Washington, D.C.

A special edition of "The Worker," an east coast Communist newspaper, and copies of "The Militant" and the "Young Socialist," publications of the Socialist Workers Party and its youth affiliate, Young Socialist Alliance, were distributed during the march.

Major demonstrations in support of the march took place in Chicago, San Francisco, and Los Angeles. Communist Party members and other individuals with subversive backgrounds participated in each of these demonstrations. The largest demonstration took place in San Francisco where 2,000 gathered at the Federal Building and heard speeches delivered by representatives of such Communist splinter groups as the Socialist Workers Party, Young Socialist Alliance, Progressive Labor Movement, and May 2 Movement.

At a meeting of the Communist Party's National Committee held in late April 1965, Michael Zagarell claimed that the Communist Party played a decisive role in the April 17, 1965, march on Washington, even though it was not there in name. In this regard, Arnold Johnson praised the march and said that party people from all over the country were in Washington for the march. Credit is due, Johnson added, to the stimulus given to the march by the Du Bois clubs.

DU BOIS CLUBS ACTIVE IN PROTESTS

Participation in a protest against U.S. policy in Vietnam was not a new experience for members of the Du Bois Clubs. In Chicago, for instance, members were involved in demonstrations protesting American action

in Vietnam on two occasions in February 1965. Du Bois Club members were among some 300 individuals involved in a similar protest in Los Angeles on February 13, 1965. On February 27, 1965, members demonstrated in Newark, N.J., against American activities in Vietnam. Richard Healey, the son of Dorothy Healey, chairman of the Communist Party's southern California district, led Communist Party, U.S.A., and Du Bois Club members in a picket line in Portland, Oreg., on February 27, 1965, opposing U.S. policy in Vietnam.

By its participation in these demonstrations, the Du Bois Clubs is following the Communist Party, U.S.A., line on Vietnam just as it has paralleled Communist policy since its founding in June 1964. Nevertheless, the national office of the Du Bois Clubs sent to all its chapters in March 1964, an "Emergency Memo on Vietnam Crisis." In this memorandum, the opinion was expressed that it was now possible to mobilize massive support for a movement to bring peace to Vietnam. It was further stated that the Du Bois Clubs was circulating in colleges and universities a petition of refusal to serve in the Armed Forces against the people of Vietnam. The memorandum called upon all chapters, members, and friends of the Du Bois Clubs to join with all groups and individuals in a "stepped-up campaign to end the war in Vietnam."

UNITED FRONT APPROACH

At a meeting of the national committee of the Communist Party in April 1965 Gus Hall characterized the situation in Vietnam as a war of U.S. imperialist aggression and compared the present action of the U.S. Government in Vietnam to fascism in Nazi Germany. He claimed that people throughout the world are protesting U.S. aggression and calling this country an outlaw. Continuing this condemnation of his native country, Hall maintained that U.S. imperialism is the principal obstacle to peace in the world today and that this country is the only power which has not abandoned war as an instrument of diplomacy.

Hall instructed that each party district should make a survey of the people's political action groups in its territory, should not be afraid of becoming involved in united front activities, but should work with any force willing to accept Communist assistance. Hall also stated that a victory over present U.S. policies in Vietnam would be a victory for coexistence. In conclusion, Hall claimed that officials and members of the Communist Party have taken part in the leadership, planning, and initiation of recent mass actions in the United States.

Demonstrations, telegrams, and letterwriting campaigns similar to those which have been described can be expected for as long as our Nation remains the principal deterrent to Communist designs to conquer the world. While the Communists may not be the instigators of a particular action of this type, it can be expected that they will make every effort to exploit any activity initiated by

non-Communists which can be used to further Communist objectives.

Mr. DELANEY. Mr. Speaker, I have no further requests for time. I move the previous question.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965

Mr. HARRIS. Mr. Speaker, I move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2986) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

The SPEAKER. The question is on the motion offered by the gentleman from Arkansas.

The motion was agreed to.

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill H.R. 2986 with Mr. PHILBIN in the chair.

The Clerk read the title of the bill.

By unanimous consent, the first reading of the bill was dispensed with.

The CHAIRMAN. Under the rule, the gentleman from Arkansas [Mr. HARRIS], will be recognized for 1 hour and the gentleman from Illinois [Mr. SPRINGER], will be recognized for 1 hour. The Chair recognizes the gentleman from Arkansas.

Mr. HARRIS. Mr. Chairman, I am pleased to present to the House this afternoon this most important legislative proposal, H.R. 2986. This bill was reported by the Committee on Interstate and Foreign Commerce unanimously. It is a very necessary legislative program, one of great interest and great importance. It would extend four present legislative authorizations for community health services under the Public Health Service. First, the community immunization program enacted 3 years ago would be extended for an additional 3 years at the current authorization appropriation level of \$11 million a year. The present program, which is limited to immunization against polio, diphtheria, whooping cough, and tetanus would be broadened to include immunization also against measles, and the Surgeon General would be authorized to add these programs against other diseases of a serious nature, if the vaccines against such diseases become available during the next few years.

Secondly, the bill provides for the extension of the present law relating to migratory workers' health service programs, which was also enacted 3 years ago. This program is extended for an additional 3 years at the present \$3 million a year appropriation authorization.

Thirdly, the 5-year authorization for grants to States to establish and maintain adequate community health services and for the support of a training program in schools of public health would

be extended for an additional year through June 30, 1967.

The \$50 million annual appropriation presently authorized for this program would not be changed.

Finally, Mr. Chairman, the program of special projects for community health services which was authorized by the Community Health Services and Facilities Act of 1961 would be extended for an additional year with no change in the \$10 million annual appropriation authorization.

Let me explain these various programs in more detail.

First, the immunization program in section 2 of the bill provides for the extension and expansion of the current vaccination programs. Since the enactment of the Vaccination Assistance Act of 1962 significant progress has been made. During the period of 1962 to 1964 the number of poliomyelitis cases in the United States was reduced from 910 to 121. Diphtheria is down from 444 to 304. Tetanus is down from 322 to 271. In 1962 only one-third of the children under 5 years of age were adequately immunized against polio. As of September 1964 two-thirds of all children under the age of 5 were protected.

Millions of people, adults and children alike, have been immunized during this 2-year period.

Although substantial progress has been made, the total impact of the vaccination program has not been realized. Extension of the program will provide time and funds to assure that the people of the Nation, particularly the children, are fully protected against these four serious communicable diseases—polio, diphtheria, whooping cough, and tetanus.

A primary aim of H.R. 2986, however, is to launch a nationwide immunization program against measles. This common childhood disease is one of the most infectious and serious of the diseases which attack children. Each year approximately 4 million cases of measles occur in the United States, causing about 500 deaths and leading to serious complications, such as measles encephalitis, pneumonia, and hearing disorders. Modern medical research has provided vaccines which can prevent the disease, and yet measles continues to take its toll among the children of our Nation. Under the authority provided in this bill, States and communities will be assisted in the conduct of comprehensive immunization programs. This will be a major effort against measles and at the same time, the work that still needs to be done against polio, diphtheria, whooping cough, and tetanus will be continued.

MIGRATORY WORKERS HEALTH SERVICES PROGRAM

Section 3 of the bill extends for 3 years the current program of project grants for domestic agricultural migratory workers.

The need for funds to help support health services for more than 1 million farm migrants—including workers and families—was well documented when the original authorizing legislation was pending before Congress in 1962. The people are poor and cannot afford to purchase the medical care they need. Yet

they fail to qualify as legal residents in their temporary work communities and are thus excluded from community services for other indigent persons. Many communities which need their labor for brief periods are small and isolated. Some have meager health resources even to serve local residents. These resources are severely overtaxed by a periodic influx of migrants.

Congress established the current migrant health project grant program in 1962. The program has demonstrated its possibilities for helping migrants to obtain needed health care. About 40-percent of the total budgeted costs of the 63 projects in 32 States assisted by migrant health grants has come from other than grant sources.

Through grant-assisted projects, night clinics provide needed care for all family workers in or near large labor camps and nurses make regular camp visits. Sanitarians work with growers and with migrants to upgrade labor camps and health educators teach the migrants how to take better care of themselves in order to prevent illness and disability to the extent possible.

So, Mr. Chairman, the program is now operating effectively and we think warrants continuation.

In addition, many more migrant workers' work areas need to develop projects.

A further need is for the addition of hospital care to the services which can be supported by migrant health grants. With the extension of this legislation, project support can be continued as necessary, hospital care can be added to project services and new migrant work areas can be encouraged to develop health services where they are needed.

Mr. Chairman, the extension of this program has been endorsed by the American Medical Association, the American Public Health Association, the Association of State and Territorial Health Officers, and other interested groups.

Many public and voluntary organizations have demonstrated their interest by the active promotion and participation in migrant health project development.

Mr. Chairman, this has been truly a cooperative program and it has worked out literally that way.

The CHAIRMAN. The time of the gentleman from Arkansas has expired.

Mr. HARRIS. Mr. Chairman, I yield myself 5 additional minutes.

Now, finally, Mr. Chairman, with reference to the general public health services, section 4 of the bill provides for a 1-year extension of the current program under section 314(c) of the Public Health Service Act. Under this program the Public Health Service makes grants on a formula and matching basis to the States to assist them in establishing and maintaining adequate State and local public health services.

The category of diseases and conditions for which grants are made to all the States include general health services, dental health services, mental health services, chronic illness and aging health services as well as radiological health services.

Mr. Chairman, for fiscal 1965 the appropriations totaled \$34,020,000 under this section. The administration this year has requested \$34,570,000, which is about the current level. In addition to the above-mentioned programs, the Public Health Service makes grants under this section to 11 schools of public health to assist them in carrying out the public health training responsibilities. There is an annual authorization of \$50 million for all the programs authorized by this subsection and a \$2.5 million annual sub-ceiling on the grants to schools of public health.

So, Mr. Chairman, this bill would extend this section 314(c) for 1 additional year beyond its current June 30, 1966 expiration date with no change in the annual authorization.

The purpose of this amendment is to permit a thorough study to be made of the programs being carried out under the present authorization and to develop legislative recommendations as to where their effectiveness may be increased. These studies are being carried out in cooperation with the State health officers and State mental health officers.

Section 5 of the bill dealing with special project grants for community health services provides a 1-year extension of section 316 of the Public Health Service Act under which project grants are made for community health services.

Section 316 of the Public Health Service Act authorizes the Surgeon General to make special project grants to public and voluntary agencies for studies and demonstrations relating to development of new or improved health services, particularly for the chronically ill and aged.

Since the enactment of this authorization as part of the Community Health Services and Facilities Act of 1961 grants have been made to almost 200 projects in 40 States which will result in the development, extension, and improvement of a wide variety of essential community health services for the chronically ill and aged outside the hospital.

The 1-year extension of this program beyond its current expiration date, with no change in the \$10 million annual appropriation authorization, will permit an evaluation of its effectiveness to be conducted as part of the study I have just mentioned.

Mr. Chairman, the Committee on Interstate and Foreign Commerce believes this is a reasonable bill and an important one. We conducted hearings which lasted for a period of several days. The Secretary of Health, Education, and Welfare led off as the first witness. We had extended support for the bill from various organizations, and the committee determined that the bill was justified and in the interest of the public.

Mr. Chairman, the Senate has passed a similar bill which extends the programs similarly to the House bill. It increases certain authorizations of these various programs. We feel that, with the approval of this bill, we can go to conference with the Senate in an effort to bring back the best possible program to meet this need.

(Mr. HARRIS asked and was given permission to revise and extend his remarks.)

Mr. SPRINGER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am happy to have been coauthor of this important and timely legislation.

In the year 1955, the Federal Government reached a decision to use its resources to fight diseases that knew no State boundaries and the results of which called for immediate action if many thousands of American children were to be spared the horrors of crippling polio. Since that time the fight has gone on using the combined resources and talents of government, industry, and the medical fraternity. There is no need to detail the struggle or the results. We have seen polio eliminated as a threat to the public health of our citizens. Thank God for the dedication and foresight of those who brought it about.

During these years the battle has also been waged against other diseases and so far as they posed a continuing threat to the very young we have considered them national problems. If any one program in the field of health can be pointed to as an unqualified success it is the immunization program. Not always can we see the results around us day by day, but in this case any parent can sense the relief which comparative safety from these dread diseases must bring.

This modest program has been running \$11 million per year. If we were requested to renew this expenditure just to continue present activities it would be worthwhile. There is, however, great promise at this time for a vaccine to stamp out measles, that childhood disease which brushes by thousands of children but singles out some to suffer lasting effects, such as mental retardation or hearing disorders.

No increase in funds is authorized in the present bill. It contemplates rather that the same efforts be now transferred to combat measles. The specialists in this field think it can be conquered. We hope so. Certainly we should try.

Other vaccines are still being developed. At least one more may prove itself before the end of the 3-year period contemplated for the extension of this effort by H.R. 2986. Should one be ready for general distribution this bill would allow a start to be made toward general immunization in the same pattern heretofore used. It is not contemplated that much more than the measles will be tackled during the 3-year period, but it would be unwise to hold back favorable possibilities in so vital an area.

I recommend that the immunization program be continued as set forth in H.R. 2986.

A second program outlined in this bill is also a continuation of a present effort. Federal assistance for migratory workers is somewhat more controversial surely than national immunization from dreaded diseases. When the matter is carefully examined, however, in the light of the problem and the very modest part the Federal Government has seen fit to take, it appears on balance that it should be continued at its present level. Although the agency concerned suggests

first that no ceiling be placed on this authorization, it has been the practice of this body to make the necessary determination to set the spending level beforehand. Once it became clear that this was intended a figure far above present expenditures was suggested. Meanwhile, the other body did report out a bill on the same subject providing for increases. It was the determination of your committee that the level of present expenditures, \$3 million per year, should be maintained.

That migratory workers bring new and unusual problems to a community cannot be denied. Those responsible for the very rudiments of public health and for the protection of the community from diseases imported with such labor find themselves completely swamped. Hospital care for some of these laborers will be necessary and the handling of such expense within the existing institutions becomes very complicated. As much as anything else such a city or county needs more trained manpower to cope with this temporary situation.

Management can and must do much more to accept the burden of providing adequate health care. Partly because of this the Federal Government has not made any move to accept the whole problem as its own. This is right. But we must and do recognize that the situation of the migratory worker is not solved by pointing a finger at anyone and saying, "Take over, the responsibility is all yours." This modest government-to-government assistance takes the correct approach and merits being continued at this time.

The question has been asked whether or not the assistance provided in this part of H.R. 2986 is not duplicated in other programs underway or about to be started. As far as the legislation now in being and the actions said to be contemplated by the executive thereunder we do not find duplication.

For nearly 10 years now Congress has been authorizing and appropriating money to assist States and other local entities in the establishment and maintenance of public health services. Some areas such as mental health and chronic illness come to deserve more attention and we have added these to the categories for which grants may be given. In 1961 the overall authorization was raised from \$30 million per year to \$50 million per year. The actual expenditures have been running about \$35 million per year.

This money is parceled out on a formula basis to all the States and used mainly to finance adequate manpower for the health departments across the Nation.

At present a study is underway to analyze this whole program and for this reason only a 1-year extension is suggested.

Also under study and also to be extended for 1 year only is the remaining program included in the bill—special grants. During the last 3 years we have provided funds for demonstration and experimental projects which might show the way to better health care and the better methods of treatment for various diseases of the chronically ill. Obviously

the main purpose of this experimenting is to find ways to cope with the increasing problems caused by the number of aging citizens among us. Much of value will be learned. Two examples of projects now underway should show you better what is being done.

One project in Ohio will try to determine whether home care for the chronically ill and aged through homemaker services will prevent unnecessary hospitalization for the group, and whether the homemaker can provide basic services; or whether she must be further assisted by outside services such as meals-on-wheels, volunteers or other community services.

Another project in Michigan will establish a training program in home care as a joint effort of the School of Public Health and the Visiting Nurses Association of Detroit. There will be 4-day institutes in each of 3 years. Materials developed will be incorporated into a training manual for use by communities.

I recommend the extension of this program and the others included in H.R. 2986.

Mr. SPRINGER. Mr. Chairman, I yield 10 minutes to the gentleman from Massachusetts, Mr. KEITH.

Mr. KEITH. Mr. Chairman, I rise to express my general support for the Community Health Services Extension Amendments which we are now considering. This measure is necessary in order that there will be a continuation of certain important programs carried on under parts of the Public Health Service Act.

Other speakers have addressed themselves to the individual sections of that act which will now be extended under this legislation. I agree with my chairman, who has given his support to these extensions and asked the House for its approval of the bill in its entirety.

I would like to point out to my colleagues, however, that the other body has considered this legislation and has passed an amended version. I would like to speak for a moment in support of one of the Senate amendments.

At the present time we have 12 schools of public health in the United States. They perform a very valuable service for this country and are a principal source of professional public health personnel for local, State, and Federal Government agencies.

I might say, Mr. Chairman, since the chairman of our committee, my colleague from Arkansas, outlined the great progress that has been made in reducing the numbers of cases of diphtheria, and other contagious diseases by our immunization program, that this program is implemented by, in most cases, graduates of the schools of public health. Unless we have strong, and competent schools of public health we will not have the personnel to administer this program in all of its aspects.

The formula grants which are made under section 314(c) of the Public Health Service Act now amount to \$2.5 million, and are used to assist these schools in providing vital public health training. The schools are reimbursed in part for teaching costs.

Last year the Congress approved the Graduate Public Health Training Amendments of 1964, which more than doubles the amount of Federal support to individuals for public health training. This will result in an increase in the number of professional public health students; therefore, additional support for the schools is also needed if they are to maintain the high level of training that is now offered.

In addition, in the very near future, two new schools of public health will be established. This will further dilute the amount that each school will receive for support of the training it provides.

Mr. Chairman, the other body has raised the amount of formula grants to these schools from \$2.5 to \$5 million with no increase in the total \$50 million authorization in the bill. I strongly recommend that we accept this amendment and concur that this amount is needed in order that the important role performed by these schools be continued. I do not believe that it would be in the public interest to wait another year before granting these increased funds.

The formula grants to the States will undergo a complete review in the next year. However, the grants to these schools of public health are not to be included in this review. Their needs are separate from the needs of the State agencies.

Mr. Chairman, I do not now offer an amendment to H.R. 2986 to increase the amount going to these schools. However, I strongly urge my colleagues to consider accepting in conference, S. 510 which incorporates this and other minor amendments. I emphasize that this amendment does not change or increase the overall \$50 million ceiling in the whole bill. It merely provides for an increase in this particular item.

Mr. Chairman, I hope when the House Members go to conference with the Senate that we will concur in the Senate version with reference to the question of assisting our public health schools.

I yield back the remainder of my time.

Mr. HARRIS. Mr. Chairman, I yield such time as he may require to the gentleman from Texas, Mr. PICKLE.

(Mr. PICKLE asked and was given permission to revise and extend his remarks.)

Mr. PICKLE. Mr. Chairman, each year at this time, many thousands of migratory workers begin moving northward from the border areas of Texas. It is estimated that some one million such persons—including workers and family dependents—move during each crop season in response to seasonal farm labor demand.

These migrants live and work for brief periods in many parts of the Nation before returning in the fall to areas of the South and Southwest. Their health needs are quite acute because of low income, lack of education, and their unfortunate isolation from communities and their health services. Their annual earnings, I am advised, average less than \$1,000 per worker.

We in Texas are proud of the good work being done to provide much-needed

health services to our migratory workers. As you know, Mr. Chairman, the Congress in 1962 first enacted legislation providing grants for family health service clinics and other health services to migratory agricultural workers.

This program expires on June 30, this year, unless extended as proposed by this measure now before us. I urge the House to give its full support to H.R. 2986 not only because of the migratory workers provision, but to maintain the effective immunization program which is rapidly reducing our rate of communicable diseases throughout the Nation, and to continue the many special project grants to the States for general and community health services.

Mr. HARRIS. Mr. Chairman, I yield such time as he may require to the gentleman from Florida [Mr. ROGERS].

(Mr. ROGERS of Florida asked and was given permission to revise and extend his remarks.)

Mr. ROGERS of Florida. Mr. Chairman, I thank the gentleman from Arkansas.

I rise in support of this legislation. As a member of the Interstate and Foreign Commerce Committee I was pleased to have played a part in committee formulation of this bill.

This measure extends the provisions of several programs which are of great importance to the Nation and to Florida. One of those programs is the health service extended to domestic migratory farmworkers and their dependents. The original legislation enacted in 1962, and which I supported, allowed for grants for family service clinics and related health care centers for such workers. A total of 29 States and Puerto Rico received funds under this program, and its scope affects over 1 million farmworkers and their dependents.

The widespread health problems afflicting this group of workers are compounded by illiteracy and lack of permanent residence. Their health problems become those of the communities which they visit, and they work and live on a temporary basis in nearly one-third of counties of America.

In Florida some \$269,851 were received last year under this program for operations of these facilities. In Palm Beach County, where a large number of these workers come each year to work in a variety of crops, mobile health centers have been made possible under this program, and just this season alone covering from November 1 thru last week, almost 1,400 calls were made by migrant workers in need of care. In 1964, the Palm Beach County Health Department administered 1,328 immunizations to migrant workers.

This is but one example of the great number of counties and communities assisted under the programs contained in this extension. I urge the membership to again recognize the merits of this legislation and approve these existing provisions by extending them.

Mr. HARRIS. Mr. Chairman, I am happy to yield now to my distinguished colleague and my neighbor, the gentleman from Louisiana [Mr. WAGGONER].

(Mr. WAGGONER asked and was given permission to revise and extend his remarks.)

Mr. WAGGONER. Mr. Chairman, I support H.R. 2986 which amends and extends certain expiring provisions of the Public Health Service Act that relate to community health services. I want to commend my colleague from Arkansas [Mr. HARRIS] for his leadership in this matter. These planned immunization programs are improving the health of this Nation. Defects such as mental retardation are being reduced. Deaths are being reduced and our Nation benefits. Surely we can all support the able and capable chairman of this committee, the gentleman from Arkansas [Mr. HARRIS], in this effort.

(Mrs. SULLIVAN (at the request of Mr. HARRIS) was given permission to extend her remarks at this point in the RECORD.)

[Mrs. SULLIVAN addressed the Committee. Her remarks will appear hereafter in the Appendix.]

Mr. HARRIS. Mr. Chairman, I yield such time as he may require to the gentleman from North Carolina [Mr. KORNEGAY].

(Mr. KORNEGAY asked and was given permission to revise and extend his remarks.)

Mr. KORNEGAY. Mr. Chairman, I rise in support of this bill now pending before the House.

[Mr. KORNEGAY addressed the Committee. His remarks will appear hereafter in the Appendix.]

GENERAL LEAVE TO EXTEND

Mr. HARRIS. Mr. Chairman, I ask unanimous consent that all Members may be permitted to extend their remarks at this point in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

Mr. FOGARTY. Mr. Chairman, I rise to express my strong endorsement of the Community Health Services Extension Amendments of 1965 and urge their enactment.

The bill before you would authorize the Public Health Service to move forward with four important health programs which have conclusively demonstrated their effectiveness.

Taken together, these four programs bring better health protection to all our people. They are of special benefit to the two segments of the population in greatest need of health care—the very young and the aged—and to our domestic migratory agricultural workers whose health conditions in the past have been a national disgrace.

The very young are the special beneficiaries of the Vaccination Assistance Act of 1962, which would be extended and expanded by the amendments before you. The great forward sweep of medical research has brought a growing number of diseases within our powers of control. The Vaccination Assistance Act was designed to bring four totally preventable diseases—polio, diphtheria, tetanus, and whooping cough—to the

point of eradication. Thanks in considerable measure to the vaccination assistance program, their toll is now declining at a rapid rate. Still the work must continue, and oncoming generations must receive protection if all our children are to be forever free of these ancient and deadly enemies.

Moreover, safe and effective protection is now possible against measles—a dangerously underrated disease which strikes 4 million children annually, kills several hundred, and leads to such life-long impairments as mental retardation and deafness in thousands more. The amendments under consideration would add measles to the list of immunizations for which the Public Health Service may furnish technical and financial aid to States and municipalities, and authorize the appropriation of sufficient funds to make a major impact on this disease.

A second element of the Community Health Services Extension Amendments is the Migrant Health Act of 1962, also due to expire at the end of the current fiscal year. In its 3-year history this act has led to the establishment of family health clinics and other services for domestic migrant farmworkers in 29 States and Puerto Rico—services which are desperately needed and in desperately short supply. This is an impressive beginning. But many of these people, upon whom much of our agricultural production depends, have not yet been reached. Their need is no less acute, their situations no less hopeless unless this kind of aid continues.

The Nation's growing number of chronically ill and aged derive the chief benefit from the Community Health Services and Facilities Act of 1961. This is a program of grants to test and demonstrate effective new ways of delivering better health care outside the hospital. Nearly 200 such projects in 40 States are underway. Through them, people are getting health care when and where they need it most.

The legislation before us would extend this program—correctly termed a milestone in public health—until June 30, 1967. It would also extend to the same date the Public Health Service's program of grants to the States to support general public health services under section 314 (c) of the Public Health Service Act, including dental health, radiological health, and others. This section also provides urgently needed support for the Nation's schools of public health—our principal reservoir of public health manpower.

Thus we have at hand the opportunity to continue and strengthen programs to immunize our children, encourage better health services for the elderly, and bring the benefits of health care to migrant agricultural workers. I wholeheartedly recommend enactment of the Community Health Services Extension Amendments of 1965.

Mr. SPRINGER. Mr. Chairman, I yield such time as he may require to the gentleman from Georgia [Mr. CALLAWAY].

(Mr. CALLAWAY asked and was given permission to revise and extend his remarks.)

Mr. CALLAWAY. Mr. Chairman, I rise in support of this bill.

As a member of the committee reporting H.R. 2986 to the House, I wish to indicate here my identification with the report submitted and with the remarks already made by our chairman, the gentleman from Arkansas [Mr. HARRIS], and our ranking minority member, the gentleman from Illinois [Mr. SPRINGER].

Immunization of our youngsters could well be characterized as the most successful and meaningful program in the entire field of public health. We can all recall the day when tetanus was a feared killer of children. Not so today. More recently we have observed firsthand the virtual elimination of polio as a threat. For the very modest outlay of \$11 million per year we have accomplished these miracles. Now we find that measles can be attacked in the same way and with the same dramatic results. Were the price far greater it would still be a bargain.

Assistance to communities which find themselves overwhelmed by the social problems caused by the influx of migratory workers is justified. The small grants made under this legislation help obtain trained manpower to carry out our basic public health programs. About 100 countries have required such aid. Eventually we can expect that the communities, working with employer groups, will work out their problems.

For some years now the Federal Government has supplied funds to help States and local governments establish and build adequate and competent public service organizations. Taken in conjunction with the efforts to train more people in these skills, it becomes the kind of really useful help which reaches down to the individual citizen.

The remaining program included in H.R. 2986 is only 3 years old but is doing an important job. As the problems of the aging become more prominent we need actively to look for long-range solutions. One good way to conduct the search is through experimental and demonstration projects which try new methods. Ideas so developed can be used in making the best use of funds, facilities and personnel in the future. Here we propose one more year at the present funding and then a review of accomplishments and an assessment of results. I foresee more and better health care for that increasing segment of our population—the aging.

This is good legislation and I support it.

Mr. SPRINGER. Mr. Chairman, I yield such time as he may desire to the gentleman from Kentucky [Mr. CARTER].

(Mr. CARTER asked and was given permission to revise and extend his remarks.)

Mr. CARTER. Mr. Chairman, I rise in support of H.R. 2986. This bill extends the duration of the current immunization program for an additional 3 years and extends coverage to include assistance in immunization programs against measles and other diseases presenting a major public health problem.

The bill also extends for an additional 3 years the current program under

which health services are provided to domestic agricultural migratory workers.

The current program authorizes \$50 million annually for grants to the States for health services.

The first major program for Federal assistance for immunization programs was established in 1955 with enactment of the Poliomyelitis Vaccination Assistance Act. In 1962, Congress enacted the Vaccination Assistance Act authorizing grants for a 3-year period to assist States and local communities in carrying out extensive vaccinations against poliomyelitis, diphtheria, pertussis, and tetanus.

Measles immunizations will be added to the program in this bill. It is estimated that approximately 4 million cases occur yearly, resulting in at least 500 deaths and in extensive complications such as mental retardation, pneumonia, hearing disorders, and encephalitis. Two vaccines recently developed have been proven quite effective. Measles immunization will prevent most of these dread conditions which have followed measles.

In years of practice, I have seen many cases of measles and of the disabling results therefrom. Immunization will be a great step forward to insuring healthier, stronger, and happier children.

Under this act, immunizations may also be extended to cover other diseases now under investigation: rubella (German measles), which causes deformities of children born of mothers who have this disease; influenza, and combined live vaccines—measles, smallpox, and yellow fever.

I unhesitatingly recommend passage of the present bill in its entirety to insure improvement of the physical and mental health of our children.

[Mr. HARRIS addressed the Committee. His remarks will appear hereafter in the Appendix.]

Mr. SPRINGER. Mr. Chairman, I have no further requests for time.

Mr. HARRIS. Mr. Chairman, I have no further requests for time.

The Clerk read as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "\$11,000,000" and by inserting "and such sums as may be necessary for each of the next five fiscal years" immediately after "June 30, 1965.". The second sentence of such subsection is amended by striking out "the fiscal years ending June 30, 1963, and June 30, 1964" and inserting in lieu thereof "any fiscal year ending prior to July 1, 1970". The third sentence of such subsection is amended by striking "and tetanus" and inserting in lieu thereof "tetanus, and measles", and by striking out "under the age of five years" and inserting in lieu thereof "of preschool age".

(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds

represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future."

(c) Subsection (b) of such section is amended by striking out "of limited duration" by striking out "against poliomyelitis, diphtheria, whooping cough, and tetanus" and inserting in lieu thereof "against the diseases referred to in subsection (a)", and by striking out "who are under the age of five years" and inserting in lieu thereof "of preschool age".

(d) Such section is further amended by striking out "intensive community vaccination" wherever it appears in subsections (a), (b), and (c) and inserting in lieu thereof "immunization".

MIGRATORY WORKERS HEALTH SERVICES

SEC. 3. Section 310 of the Public Health Service Act is amended by striking out "the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965" and inserting in lieu thereof "each fiscal year ending prior to July 1, 1970", and by striking out "any year" and inserting in lieu thereof "any year ending prior to July 1, 1965".

GENERAL PUBLIC HEALTH SERVICE

SEC. 4. The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

Mr. DANIELS. Mr. Chairman, it has been my privilege, as chairman of the Subcommittee on Retirement, Insurance, and Health Benefits of the Post Office and Civil Service Committee, to conduct public hearings and a related study in depth of the Government employees' life insurance program. On the basis of the hearings and study, I introduced H.R. 6926 which is before the House of Representatives for approval today.

The enactment of H.R. 6926 will strengthen and modernize the life insurance program established by the Government Employees' Life Insurance Act of 1954 but which has not been materially changed during the ensuing 11 years. That act was written by the Post Office and Civil Service Committee and, at the time, constituted a valuable and fully justified new employee fringe benefit. However, I am sure that neither our committee nor the Congress in 1954 intended that the provisions then drafted should constitute an ironclad limitation on the life insurance program that could not be changed and adjusted, from time to time, as conditions warranted. On the contrary, my discussions with senior Members—and particularly with our ranking minority Member, the gentleman from Pennsylvania [Mr. CORBETT]—have convinced me that future changes to keep abreast of the times were both anticipated and expected when the law was written in 1954.

I should like to take a moment now to commend the wisdom and the fore-

sight of our predecessors in writing the basic framework for an employee life insurance program into the permanent body of the law. In truth and in fact, the Government Employees' Life Insurance Act has proved out to be one of the finest employee programs ever adopted—in the interest of both the Government and its personnel. But changes in the structure and manning of our Government posts, and in the economic necessities of those who carry out essential public programs, require constant vigilance and attention by the Congress to keep abreast of the times.

This, then, is essentially the background for the development of H.R. 6926. When the Life Insurance Act was written in 1954, it placed Government employees substantially on a par with their fellow workers in private enterprise with respect to life insurance protection with employer participation. Such no longer is the case. Our Federal employees' life insurance plan has remained dormant, in terms of relative employee-employer contributions, while being far outstripped by employer support and contributions to private industry employees' life insurance.

One of the issues considered during the public hearings was whether the Congress should act now or await the recommendations of a special panel that has been appointed by the President to study Federal employees' fringe benefits, including life insurance. No report or recommendation can be expected from the panel until late in the current year. In the meantime, of course, many employees will pass away and, to the extent there is any inadequacy in their life insurance plan, their surviving widows and children may suffer loss.

During the course of the public hearings it was disclosed that the Bureau of Labor Statistics in the Department of Labor has made two pertinent investigations of private enterprise health and insurance plans, and has published comprehensive reports of the results. The first, printed as Bulletin No. 1330 of the Department of Labor, is entitled "Digest of 100 Selected Health and Insurance Plans Under Collective Bargaining, Winter 1961-62." The second, supplementing the first and printed as Department of Labor Bulletin No. 1377, is entitled "Digest of 50 Selected Health and Insurance Plans for Salaried Employees, Spring 1963."

I will not burden the RECORD with the voluminous statistical data contained in these two bulletins. Suffice it to say that, in my judgment and that of our committee, they constitute overwhelming official evidence that our Government employees' life insurance program lags far behind current policies and practices in enlightened private industry. Approximately 40 percent of the major firms surveyed pay the full cost of life insurance—subject to moderate dollar limitations in some cases—and nearly all pay a larger share of the cost than does the Federal Government for its employees.

In view of the foregoing, and the more than ample evidence that major adjustments in the Federal program are needed

if it is to have any reasonable comparability with private enterprise, there is frankly no excuse for delaying action until still another group or panel has "studied" the situation. It is the responsibility—indeed, the high obligation—of the Congress of the United States to determine and enunciate policies in these matters, and to maintain a standard whereunder the Federal Government will not suffer in comparison to private enterprise.

Enactment of H.R. 6926 will not, in my estimation, quite bring our Federal employees' life insurance program up to a par with the best—or even the very good—plans in private enterprise. But it will constitute a major step in the right direction. It will make provision for immediate adjustment by administrative action—without the delay of seeking legislation—at such time as the Civil Service Commission shall determine that an increase in the Government's contribution is necessary to maintain the financial integrity of the program. It will also fix a realistic maximum on the amount of life insurance that Federal employees may carry under the Government plan—commensurate with current salary levels—in lieu of the outdated, 11-year-old maximum written into the law in 1954 and unchanged since that time. Additional insurance permitted under the new maximum will be paid for on the same terms per \$1,000 of coverage as now provided by law, so there will be no drain on the life insurance finances by reason of this adjustment.

Mr. Speaker, I strongly recommend enactment of H.R. 6926 to the membership of the House.

Mr. HARRIS (interrupting the reading of the bill). Mr. Chairman, I ask unanimous consent that further reading of the bill be dispensed with.

The CHAIRMAN. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

The CHAIRMAN. The Clerk will report the committee amendments.

The Clerk read as follows:

Page 1, beginning in line 6, strike out "The" and all that follows down to and including the period in line 10, and insert in lieu thereof the following: "The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out 'and' before 'June 30, 1965' and by inserting 'and each of the next three fiscal years,' immediately after 'June 30, 1965,'"

Page 2, line 4, strike out "1970" and insert in lieu thereof "1968".

On page 3, line 1, insert "(1)" immediately after "(d)".

On page 3, after line 4, insert the following: "(2) The heading of such section is amended by striking out 'intensive vaccination' and inserting in lieu thereof 'immunization.'"

Page 3, line 10, strike out "1970" and insert in lieu thereof "1968". Page 3, beginning in line 10, strike out the comma and the following: "and by striking out 'any year' and inserting in lieu thereof 'any year ending prior to July 1, 1965.'"

The committee amendments were agreed to.

The CHAIRMAN. Under the rule the Committee rises.

Accordingly, the Committee rose; and the Speaker having resumed the chair, Mr. PHILBIN, chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2986) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, pursuant to House Resolution 357, he reported the bill back to the House with sundry amendments adopted by the Committee of the Whole.

The SPEAKER. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER. The question is on the passage of the bill.

The question was taken; and the Speaker announced that the "ayes" appeared to have it.

Mr. SPRINGER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER. Evidently a quorum is not present.

The Doorkeeper will close the doors, the Sergeant at Arms will notify absent Members, and the Clerk will call the roll.

The question was taken; and there were—yeas 347, nays 0, not voting 86, as follows:

[Roll No. 87]

YEAS—347

Abbitt	Brown, Ohio	Devine
Abernethy	Broyhill, N.C.	Diggs
Adair	Buchanan	Dingell
Adams	Burke	Dole
Addabbo	Burton, Calif.	Donohue
Albert	Burton, Utah	Dorn
Anderson, Ill.	Byrne, Pa.	Dow
Anderson, Tenn.	Byrnes, Wis.	Dowdy
Andrews, George W.	Cabell	Downing
Andrews, Glenn	Callan	Duncan, Oreg.
Andrews, N. Dak.	Callaway	Duncan, Tenn.
Annunzio	Carter	Dyal
Arends	Casey	Edmondson
Ashmore	Cederberg	Edwards, Ala.
Aspinall	Chamberlain	Ellsworth
Ayres	Chelf	Evans, Colo.
Baldwin	Clancy	Everett
Bandstra	Clark	Evens, Tenn.
Baring	Clausen, Don H.	Fallon
Barrett	Clawson, Del.	Farbstein
Bates	Cleveland	Farnum
Battin	Collier	Fascell
Beckworth	Colmer	Fisher
Bell	Conable	Flood
Bennett	Cooley	Flynt
Berry	Corbett	Fogarty
Betts	Corman	Foley
Bingham	Craley	Ford, Gerald R.
Boggs	Cramer	Ford,
Boland	Cunningham	William D.
Bolton	Curtin	Fountain
Bow	Daddario	Fraser
Bray	Dague	Friedel
Brook	Daniels	Fulton, Pa.
Brooks	Davis, Ga.	Fulton, Tenn.
Broomfield	Davis, Wis.	Fuqua
Brown, Calif.	de la Garza	Garmatz
	Delaney	Gathings
	Dent	Gettys
	Denton	Gibbons
		Gilbert

Gilligan	McDowell	Roncalio
Gonzalez	McEwen	Rooney, N.Y.
Goodell	McFall	Rooney, Pa.
Green, Oreg.	McGrath	Roosevelt
Green, Pa.	McMillan	Rosenthal
Greigg	Macdonald	Rostenkowski
Grider	Machen	Roudebush
Griffin	Mackay	Roush
Griffiths	Mackie	Roybal
Gross	Madden	Rumsfeld
Grover	Mahon	Ryan
Gubser	Mailhard	Satterfield
Gurney	Marsh	St Germain
Hagan, Ga.	Martin, Ala.	Saylor
Hagen, Calif.	Martin, Mass.	Schuer
Hailey	Martin, Nebr.	Schisler
Hall	Matsunaga	Schneebeli
Hamilton	Matthews	Schweiker
Hanley	Meeds	Scott
Hanna	Miller	Selden
Hansen, Idaho	Minish	Shriver
Hansen, Iowa	Mink	Sickles
Hansen, Wash.	Moeller	Sikes
Hardy	Moore	Sisk
Harris	Morris	Skubitz
Harsha	Morse	Smith, Calif.
Harvey, Ind.	Mosher	Smith, N.Y.
Harvey, Mich.	Moss	Smith, Va.
Hathaway	Multer	Springer
Hawkins	Murphy, Ill.	Stafford
Hébert	Murphy, N.Y.	Stalbaum
Hechler	Murray	Stanton
Helstoski	Natcher	Steed
Henderson	Nedzi	Stephens
Herlong	Nelsen	Stratton
Hicks	O'Brien	Stubblefield
Hollifield	O'Hara, Ill.	Sullivan
Horton	O'Hara, Mich.	Sweeney
Howard	O'Konski	Talcott
Hull	Olsen, Mont.	Taylor
Hungate	Olson, Minn.	Teague, Calif.
Huot	O'Neal, Ga.	Tenzer
Hutchinson	Ottinger	Thomas
Ichord	Passman	Thompson, La.
Irwin	Patman	Thompson, Tex.
Joelson	Patten	Todd
Johnson, Okla.	Pelly	Trimble
Johnson, Pa.	Perkins	Tuck
Jonas	Philbin	Tunney
Jones, Ala.	Pickle	Tupper
Karsten	Pike	Tuten
Karth	Poage	Ullman
Kastenmeier	Poff	Utt
Kee	Pool	Van Deerlin
Keith	Price	Vank
Kelly	Pucinski	Vigorito
King, Calif.	Purcell	Vivian
King, N.Y.	Quie	Waggonner
King, Utah	Quillen	Walker, Miss.
Kirwan	Race	Walker, N. Mex.
Kluczyński	Randall	Watkins
Kornegay	Reid, Ill.	Watts
Krebs	Reid, N.Y.	Weitner
Kunkel	Reifel	Whalley
Laird	Reinecke	White, Idaho
Landrum	Reuss	White, Tex.
Langen	Rhodes, Ariz.	Whitener
Latta	Rhodes, Pa.	Widnall
Leggett	Rivers, Alaska	Williams
Lennon	Rivers, S.C.	Wilson, Bob
Lindsay	Roberts	Wolf
Lipscomb	Robison	Wright
Long, La.	Rogers, Colo.	Wyatt
Love	Rogers, Fla.	Wylder
McCarthy	Rogers, Tex.	Yates
McCulloch	Ronan	Younger
McDade		Zablocki

NAYS—0

NOT VOTING—86

Ashbrook	Dwyer	Long, Md.
Ashley	Edwards, Calif.	McClory
Belcher	Erlenborn	McVicker
Blatnik	Farnsley	MacGregor
Bolling	Feighan	Mathias
Bonner	Findley	May
Brademas	Fino	Michel
Broyhill, Va.	Frelinghuysen	Mills
Burleson	Gallagher	Minshall
Cahill	Gaiamo	Mize
Cameron	Grabowski	Monagan
Carey	Gray	Moorhead
Celler	Halleck	Morgan
Clevenger	Halpern	Morrison
Cohelan	Hays	Morton
Conte	Holland	Nix
Conyers	Hosmer	O'Neill, Mass.
Culver	Jacobs	Pepper
Curtis	Jarman	Pinne
Dawson	Jennings	Powell
Derwinski	Johnson, Calif.	Redlin
Dickinson	Jones, Mo.	Resnick
Dulski	Keogh	Rodino

St. Onge	Smith, Iowa	Udall
Schmidhauser	Staggers	Whitten
Secrest	Teague, Tex.	Willis
Senner	Thompson, N.J.	Wilson,
Shipley	Thomson, Wis.	Charles H.
Slack	Toll	Young

So the bill was passed.
The Clerk announced the following pairs.

Mr. Rodino with Mr. Frelinghuysen.
Mr. Toll with Mr. Mathias.
Mr. Schmidhauser with Mr. Findley.
Mr. Monagan with Mr. Conte.
Mr. Thompson of New Jersey with Mrs. Dwyer.
Mr. Johnson of California with Mr. Hosmer.
Mr. Conyers with Mr. Flino.
Mr. Culver with Mr. Derwinski.
Mr. Feighan with Mr. Cahill.
Mr. Keogh with Mr. Thomson of Wisconsin.

Mr. Gialmo with Mr. Pirnie.
Mr. Jennings with Mr. Ashbrook.
Mr. St. Onge with Mr. McClory.
Mr. Shipley with Mr. Morton.
Mr. Burleson with Mr. Halleck.
Mr. Carey with Mr. Erlenborn.
Mr. O'Neill of Massachusetts with Mr. Curtis.

Mr. Resnick with Mr. MacGregor.
Mr. Celler with Mrs. May.
Mr. Mills with Mr. Belcher.
Mr. Morgan with Mr. Minshall.
Mr. Morrison with Mr. Dickinson.
Mr. Powell with Mr. Halpern.
Mr. Teague of Texas with Mr. Mize.
Mr. Staggers with Mr. Broyhill of Virginia.
Mr. Slack with Mr. Michel.
Mr. Cohelan with Mr. Farnsley.
Mr. Cameron with Mr. Dawson.
Mr. Long of Maryland with Mr. Brademas.
Mr. Blatnik with Mr. Whitten.
Mr. Charles H. Wilson with Mr. Nix.
Mr. Pepper with Mr. Redlin.
Mr. Gallagher with Mr. Gray.
Mr. Udall with Mr. Dulski.
Mr. Moorhead with Mr. Clevenger.
Mr. Bonner with Mr. Ashley.
Mr. Secrest with Mr. Jarman.
Mr. Hays with Mr. Senner.
Mr. Holland with Mr. Edwards of California.
Mr. Grabowski with Mr. McVicker.
Mr. Smith of Iowa with Mr. Jacobs.
Mr. Young with Mr. Willis.

The result of the vote was announced as above recorded.

The doors were opened.

A motion to reconsider was laid on the table.

HON. ROBERT E. JONES, OF
ALABAMA

Mr. HARRIS. Mr. Speaker, our distinguished colleague, the gentleman from Louisiana [Mr. THOMPSON], who just had to leave the Chamber, to keep an appointment, was going to make an announcement which all Members of the House would be glad to hear.

I have the honor of making the announcement for him. We are so glad and happy to see our colleague, the gentleman from Alabama, Bob Jones, who has been in the hospital back with us again. He is looking hale and hearty and we want to give him a cordial welcome. We are so thankful by providence that he is back with us and we are glad to see him looking so well.

COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965

Mr. HARRIS. Mr. Speaker, I ask unanimous consent for the immediate

consideration of the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, a bill similar to the one just passed by the House.

The Clerk read the title of the bill.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

The Clerk read the bill, as follows:

S. 510

An act to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "\$11,000,000" and by inserting "and \$8,000,000 for each of the next five fiscal years" immediately after "June 30, 1965.". The second sentence of such subsection is amended by striking out "the fiscal years ending June 30, 1963, and June 30, 1964" and inserting in lieu thereof "any fiscal year ending prior to July 1, 1970". The third sentence of such subsection is amended by striking "and tetanus" and inserting in lieu thereof "tetanus, and measles", and by striking out "under the age of five years" and inserting in lieu thereof "of preschool age".

(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future."

(c) Subsection (b) of such section is amended by striking out "of limited duration", by striking out "against poliomyelitis, diphtheria, whooping cough, and tetanus" and inserting in lieu thereof "against the diseases referred to in subsection (a)", and by striking out "who are under the age of five years" and inserting in lieu thereof "of preschool age".

(d) Such section is further amended by striking out "intensive community vaccination" wherever it appears in subsections (a), (b), and (c) and inserting in lieu thereof "immunization".

(e) Paragraph 1 of subsection (c) is amended by inserting "on the basis of estimates" after "advance"; by striking out the comma after the word "reimbursement" and inserting in lieu thereof "(with necessary adjustments on account of underpayments or overpayments)"; and by adding at the end of such paragraph the following sentence: "Nothing in this section shall be construed to require, or authorize any requirement of, any grantee to maintain a detailed record or provide a detailed report with respect to the age of individuals vaccinated with vaccines financed in whole or part under this section so long as such grantee maintains such records and makes such reports as the Surgeon General may require of the number of individuals actually vaccinated with such vaccines and which the Surgeon General finds that such number does

not exceed the number of children estimated by him from time to time to be within the age group or groups eligible under this section to receive such vaccines."

MIGRATORY WORKERS HEALTH SERVICES

SEC. 3. (a) Effective with respect to appropriations for fiscal years beginning after June 30, 1965, section 310 of the Public Health Service Act is amended by striking out "for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed \$3,000,000 for any year, as may be necessary" and inserting in lieu thereof "not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, \$9,000,000 for the fiscal year ending June 30, 1968, and \$10,000,000 each for the fiscal years ending June 30, 1969, and June 30, 1970."

(b) Such section is further amended by inserting "including necessary hospital care, and" immediately after "agricultural migratory workers and their families," in clause (1) (i) of such section.

GENERAL PUBLIC HEALTH SERVICES

SEC. 4. (a) The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

(b) The third sentence of subsection (c) of section 314 of such Act is amended by striking out "\$2,500,000" and inserting in lieu thereof "\$5,000,000".

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

Passed the Senate March 11, 1965.

Attest:

Secretary.

AMENDMENT OFFERED BY MR. HARRIS

Mr. HARRIS. Mr. Speaker, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. HARRIS: Strike out all after the enacting clause of S. 510 and insert the provisions of H.R. 2986 as passed:

"That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

"IMMUNIZATION PROGRAMS

"SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out 'and' before 'June 30, 1965' and by inserting 'and each of the next three fiscal years,' immediately after 'June 30, 1965.'. The second sentence of such subsection is amended by striking out 'the fiscal years ending June 30, 1963, and June 30, 1964' and inserting in lieu thereof 'any fiscal year ending prior to July 1, 1968'. The third sentence of such subsection is amended by striking 'and tetanus' and inserting in lieu thereof 'tetanus, and measles', and by striking out 'under the age of five years' and inserting in lieu thereof 'of preschool age'.

"(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: 'Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future.'

"(c) Subsection (b) of such section is amended by striking out 'of limited duration', by striking out 'against poliomyelitis, diphtheria, whooping cough, and tetanus' and inserting in lieu thereof 'against the diseases referred to in subsection (a)', and by striking out 'who are under the age of five years' and inserting in lieu thereof 'of pre-school age'.

"(d) (1) Such section is further amended by striking out 'intensive community vaccination' wherever it appears in subsections (a), (b), and (c) and inserting in lieu thereof 'immunization'.

"(2) The heading of such section is amended by striking out 'INTENSIVE VACCINATION' and inserting in lieu thereof 'IMMUNIZATION'.

"MIGRATORY WORKERS HEALTH SERVICES

"SEC. 3. Section 310 of the Public Health Service Act is amended by striking out 'the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965' and inserting in lieu thereof 'each fiscal year ending prior to July 1, 1968'.

"GENERAL PUBLIC HEALTH SERVICES

"SEC. 4. The first sentence of subsection (c) of section 314 of such Act is amended by striking out 'first five fiscal years ending after June 30, 1961' and inserting in lieu thereof 'first six fiscal years ending after June 30, 1961'.

"SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

"SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out 'first five fiscal years ending after June 30, 1961' and inserting in lieu thereof 'first six fiscal years ending after June 30, 1961'."

The amendment was agreed to.

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

A similar House bill (H.R. 2986) was laid on the table.

Mr. HARRIS. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, with a House amendment thereto, insist upon the House amendment, and request a conference with the Senate.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas? The Chair hears none, and appoints the following conferees: Messrs. HARRIS, O'BRIEN, ROGERS of Florida, SATTERFIELD, SPRINGER, NELSEN, and CARTER.

POLISH CONSTITUTION DAY

Mr. ROONEY of New York. Mr. Speaker, 174 years ago today a great milestone was passed in Europe. On that day Poland adopted a Constitution which so clearly defined the rights of citizens and so forcibly portrayed the elements of freedom and justice that freedom-loving people everywhere rejoiced in the great steps forward which Poland had taken.

Because of its great similarity to our own Constitution, which came into being only a few years earlier, our fine Polish-American organizations are wont to pay equal and deserving tribute to our own charter as they commemorate the anni-

versary of the adoption of the Polish Constitution. This constitutes one of the real reasons for Americans of Polish birth and descent having a tremendous love and respect for our American Constitution.

Mr. Speaker, we as Americans should rejoice in the fact that the document which the wise and farseeing founders of this Nation drafted was given an adequate chance to be tried and tested for generations to come.

But how tragic was the lot of Poland in contrast. Within a few years after the adoption of its superb Constitution, the Polish people were to suffer the loss of their all-too-short enjoyment of freedom and liberty and become subjected to the sorrows of enslavement as Russia, Austria, and Prussia carved up and claimed parts of their homeland.

How differently might the pages of history have been written if the Polish Constitution had had a reasonable chance to have become the document under which the people of Poland could have lived and worked in independence and under a self-determined government which would foster the dignity of unlettered men.

But even with the tragedies which befell Poland subsequent to the worldwide acclaim given its fine Constitution, the contents and the noble spirit of that document can never be forgotten. From time to time through the generations which have followed that of the framers of the famed charter, Polish leaders with the love of freedom and the welfare of the people in their hearts have gone to the Constitution for guidance and for inspiration.

And among the people of Poland there have always been those who have sought independence, who have wooed justice, because they have had an inborn love of liberty. There will always be Poles who revere the almost sacred text of the Constitution and who aspire to a life of independence.

We know the great influence which our own Constitution has had on other nations beginning with the French Revolution and extending over almost two centuries to today.

Our pride grows as we recall the meaning of our Constitution to France, Poland, Czechoslovakia, country after country in Latin America, and most recently the newly formed nations of Africa.

It is therefore incumbent upon all of us—not just those in whose veins flows the proud blood of Poland—to rededicate ourselves to the cause of freedom. As Americans we have a particular challenge to enjoy and savor the blessings of liberty in this country and to fight any and all who might attempt to deny that same enjoyment of blessings to Americans because of reasons related to race, color, religion, or ethnic background.

Ours is the challenge, too, to help perpetuate the memory of the Polish Constitution and to help perpetuate a recognition of its glory for all mankind. This we shall do to add further strength to our efforts to obtain as swiftly as possible a complete release of Poland from the external Soviet authority which today

enslaves it and secure the attainment of self-determination for all Poles now and for future generations.

Mr. Speaker, to achieve these aims we must rededicate ourselves to the task which President Johnson so ably outlined to the Polish-American organizations last September when he said:

That is why we will continue to maintain the closest relations with the people of Poland. That is why we shall try to strengthen them through bridges of people, ideas, trade and aid, regardless of temporary political obstacles we may encounter.

So it is that we shall devise a policy that will achieve freedom for the Polish people * * * a freedom that will not be accompanied by obliteration.

Mr. Speaker, we cannot truly enjoy our blessings under the magnificent Constitution of our country so long as the people of Poland suffer the deprivation of liberty and freedom which might now be theirs if the Polish Constitution so magnificently created and so happily adopted 174 years ago today were now in force.

We must meet the challenge of helping President Johnson build those bridges to bring hope and freedom to our friends and neighbors in Poland.

CAN WE HAVE A TIGHT MONEY POLICY WITHOUT DAMAGING EFFECTS TO THE ECONOMY?

(Mr. ANNUNZIO asked and was given permission to address the House for 1 minute and to revise and extend his remarks and include extraneous matter.)

Mr. ANNUNZIO. Mr. Speaker, the question of the monetary policy of this country has long interested me. But of even greater interest to me is the feeling by a group of "tight money" advocates who feel that we can adopt a restrictive money policy without damaging our economy. In fact, this group even goes so far as to say that such a tight money policy would help the economy. I fail to see even the simplest logic in this type of thinking. I share the beliefs of the distinguished chairman of the House Banking and Currency Committee, the gentleman from Texas [Mr. PATMAN], that this Nation should adopt a financial policy based on the premise of an adequate money supply to meet the needs of an expanding economy. It is impossible to use the words "expanding" and "tight money" in any sound economic policy. If they are to be used together, this would be similar to Congress saying, "The United States needs to have an expansion in the homebuilding field, but we are going to restrict the amount of building supplies that will be made available." In short, you cannot restrict and expect growth.

It has become increasingly clear in recent weeks that the Federal Reserve Board is restricting the credit needs of this country. At the present time bank reserves are at their lowest period in 5 years, thus forcing interest rates to near record highs. Our economy cannot continue to expand under the Federal Reserve Board's present restrictive monetary policy. There is no reason for such a policy, and I would hope that this Nation is not forced into an even tighter financial position simply on the basis

of a majority vote of the Board of Governors of the Federal Reserve System.

Mr. Speaker, recently two distinguished Members of this body, the gentleman from Texas [Mr. PATMAN] and the gentleman from Missouri [Mr. CURTIS], engaged in a newspaper debate on the subject of adequate or tight credit. The two articles were written for United Press International and were made available to newspapers throughout the Nation. In view of the Federal Reserve's continued efforts to tighten credit, I think it is important that the articles by the gentleman from Texas and the gentleman from Missouri be reviewed by Members of this House. Included in my remarks is a copy of both articles so that every Member of this body can see the importance of this situation.

NO. 1 BACKER OF SOFT POLICY SAYS, GOOD SUPPLY IS VITAL TO ECONOMY

(By Representative WRIGHT PATMAN)

America's public and private debt today adds up to the fantastic total of \$1,300 million.

A rise of but one percentage point in interest charges on this already extravagant aggregate of more than \$75 billion Americans are now paying as interest.

Since Biblical days, interest charges—then called usury—have frequently meant woe for the borrower and joy for the lender. Governments have passed laws to protect the borrower from extortionate rates and inhuman foreclosures.

More than five centuries before Christ, the great Athenian lawmaker, Solon, forbade men being sold into slavery because of unpaid interest charges.

In Christ's time, the money changers in the temple were not exactly held in the highest repute. Both the Jewish and Christian churches outlawed usury. But money lending still took place.

In the year 1545, England removed the prohibition on the lending of money and fixed a legal maximum interest rate. Many continental nations soon followed suit.

Today, it is imperative, as never before, that Americans center their attention on interest charges.

For many months, bankers have been propagandizing to raise the amount of interest. Americans are taxed by the private lending institutions. There has been a concerted effort to raise interest rates and to get public acceptance by one pretext or another. This despite pleas from President Johnson to hold the rates down.

The mere fact that bank profits are higher than ever before in history has made no difference. Many independent bankers are willing to let well enough alone. But few dare openly buck the banking establishment which sets policy.

According to a bit of facetious testimony by John Galbraith, the great economist, before the Joint Economic Committee recently: "Interest rates are the only price that is never raised in order to give the recipient a greater return." They're always increased "as a somber act of national policy."

DAY OF INFAMY

One day interest rates must go up because of "inflationary threats"; then the excuse is "unfavorable balance of payments." Last November 23, which I called the "day of financial infamy," our Federal Reserve System raised our discount rate 15 percent when the British raised theirs 2 percent.

The excuse offered was "to keep our investors from sending their money overseas." The very next day, our Government put \$1 billion into a \$3 billion fund to support the British pound. If ever a financial policy was working at cross purposes, this was it.

We still get a lot of chatter from the bankers' lobby about unfavorable balance of payments forcing interest rates up. Corporate investments abroad, vast defense expenditures, and foreign aid are ignored as causes for our imbalance of payments. Only higher interest rates will correct the imbalance. To this we say "hogwash."

MARTIN'S TESTIMONY

Within a day of Galbraith's testimony, William McChesney Martin, chairman of the Federal Reserve System, told the Joint Economic Committee that he thought it may be necessary to tighten credit and raise interest rates. When I asked him if he would agree to a 6-percent interest on Government bonds, he didn't bat an eye.

Such a raise would lead to a national debt of \$600 billion within 15 years, and meant that the American people would pay upward of \$36 billion a year on the public debt.

As of now, they are paying \$5.5 billion more than they should cover \$11 billion instead of \$5.5 billion, thanks to the precipitous increases brought about during the Eisenhower regime.

The tragedy of tight money and high interest rates is that ultimately they bring about economic disaster. In tandem they cause a slackening of our economic growth; the net result—more unemployment.

PAST DISASTERS

It would be perfectly absurd for America to pursue monetary policies that have invariably brought disaster in the past.

We had three manmade depressions under Eisenhower. President Kennedy brought us out of the last of these in 1961, and there were no recessions during his administration. There is no need to have any under Mr. Johnson.

To avert disaster, we need adequate credit for the small and large businessman, at reasonable interest charges.

We need a sound money policy so that the farmer won't be soaked on his mortgage, the new homeowner on his split-level. Our school systems should not have to pay unconscionably high rates to private lenders.

FEELING THE PINCH

Our municipalities are feeling the pinch of high interest rates, as are our county and State governments. Despite denials, interest charges are going up all along the line and money is harder to come by.

I never could understand why it was necessary for Uncle Sam to advance credit to private banking institutions which enables them to purchase Government securities at high interest rates. When interest on Government securities goes up, all types of borrowing cost more to the consumer. A raise of only 1 percent on a 20-year, \$10,000 mortgage will cost the home purchaser an additional \$2,000.

A raise of but 0.25 percent on the national debt will cost all Americans more than \$800 million a year additional.

I say it's time to reverse the trend. It's time for interest rates to come down and for money to be available to the legitimate borrower for legitimate business or personal reasons at fair rates. If bankers want to maintain a respectable public image, it would be wise for them to reconsider their drive for a pound of flesh.

CHEAP MONEY OPPONENT WANTS MARKET INTERPLAY TO FIX RATES

(By Representative THOMAS B. CURTIS)

Baron Rothschild, the great international banker, once observed there were only three people who really understood the meaning of money and none of them had very much of it.

Money to people in developed economies is a medium of exchange. Yet there are millions of people throughout the world who are outside a "money" economy. When exchange of goods or services occurs in such

countries, it is by barter. Unlike many other advanced economies at their present stage of development, in the United States money goes beyond cash to include credit, which goes beyond present wealth to cover future earning power.

As the economy of a nation becomes more sophisticated, the problems involved in the power "to coin money, regulate the value thereof" become inextricably interwoven with the companion power "to borrow money on the credit of the government." The quotes are from the U.S. Constitution.

In the United States the problems involved in maintaining "money" as an accurate "weight and measure" for the marketplace exchange of services, goods and savings became too cumbersome to handle through the routine congressional machinery. Accordingly, in 1913 the power to regulate the value of money (now including credit) was vested in a newly-created arm of the Congress, the Federal Reserve System.

After World War II, the problems involved in borrowing money on the credit of the United States to finance the war were so great that large sums had to be sold directly to the Federal Reserve System. As a result, the value of money seriously deteriorated.

In 1951 the Treasury Department, which is responsible for marketing the Federal debt, reached an "accord" with the Federal Reserve System which freed it from the obligation to absorb additional bonds. This to some degree separated fiscal power from monetary power. The cost of using credit instead of money (borrowing) went up, and the value of money, as evidenced by the rising price level ceased its rapid decline.

INEXTRICABLY TWINED

It is important to understand the distinction between credit and money, even though, as I have said, they become inextricably interwoven in a sophisticated economy to the extent that some credit is called money and other credit, for example, Treasury bills, is called near-money.

Credit in one sense is spending money without selling an asset, or spending money to obtain an asset by cashing in future earning power. Credit requires the use of money which can come from only two sources: (1) Borrowing someone else's money or (2) newly created money (which the Government alone, through the medium of the Federal Reserve System and the commercial banks, can "coin").

SOME MOTIVATION

If someone else's money is used, there must be some motivation to that person to save (not spend) his money and invest (let someone else spend) his money at the risk of not getting it back.

The economic incentives to save and to risk savings are called interest, dividends, and capital gains. The rate of return on money lent determines whether a person will save and at what risk he is willing to assume in lending his savings.

Government can alter the marketplace demand for and the price of credit by changing the value of money. It does this by creating more of it or withdrawing some of it, by its own borrowings or by directly lending money itself at certain rates.

POWER TO CHANGE

The Federal Reserve System has considerable power to alter the market demand by creating both money and credit. The Treasury Department by itself or working through the Federal Reserve has power to alter the market demand through its management of the Federal debt.

However, there are two disciplines outside the Government which limit both monetary and fiscal policy: (1) The actual amount of savings in the society and the willingness to risk the savings in the economic climate prevailing, and (2) the impact on our economy of economies abroad.

DIGEST of Congressional Proceedings

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HIGHLIGHTS: Sen. Harris criticized fees established under Land and Water Conservation Fund. Sen. Kuchel urged increased production of "quality" cotton to compete with synthetics. Rep. Ashbrook criticized alleged "partisan policies" to promote passage of farm bill. Rep. Purcell urged passage of farm bill.

SENATE

1. FORESTRY. The Interior and Insular Affairs Committee reported with amendments S. 1764, to authorize the acquisition of certain lands within the boundaries of the Uinta National Forest, Utah (S. Rept. 467). p. 16743
2. VETERANS' BENEFITS. By a vote of 69 to 17, passed as reported S. 9, to give cold war veterans educational and home-loan benefits similar to those of World War II and Korean conflict veterans, including institutional on-farm training and home and farm loan assistance by the Veterans Administration. pp. 16672-4, 16676-7, 16679-82, 16684-724

3. LANDS. The Interior and Insular Affairs Committee voted to report (but did not actually report) S. 625, with amendment, to authorize the sale of certain or disconnected tracts of land, and S. 1190, to provide that certain limitations shall not apply to certain land patented to Alaska for the use of the University of Alaska. p. D665
4. RECLAMATION. The Interior and Insular Affairs Committee voted to report (but did not actually report) S. 34, with amendment, to make certain provisions in connection with construction of the Garrison diversion unit, Missouri River Basin project. p. D665
5. RESEARCH. Passed as reported S. 949, to authorize a 5-year program of matching grants to the States by the Commerce Department in a cooperative effort to promote the wider diffusion and more effective application of the findings of science and technology throughout commerce and industry. pp. 16728-32
6. HEALTH. Conferees were appointed on S. 510, to extend and amend certain expiring provisions of the Public Health Service Act relating to community health services (p. 16672). House conferees have already been appointed.
7. USER CHARGES; CONSERVATION. Sen. Harris criticized user charges established under the Land and Water Conservation Fund, urged enactment of legislation to give Congress veto power over any fees established by Federal agencies, and inserted an Okla. Legislature resolution in support of his position. p. 16645
8. COTTON. Sen. Kuchel urged increased production of "quality" cotton to compete more effectively with synthetics, expressed opposition to payment of price supports "on cotton that is not of sufficiently high quality to be used in our high-speed and efficient modern textile mills," and inserted a letter from the president of the Western Cotton Growers Assoc. in support of his position. p. 16657
9. HOUSING LOANS. Conferees were appointed by both Houses on H. R. 7984, the housing and urban development bill. pp. 16555, 16700
Sen. Byrd, W. Va., inserted an article by Vice President Humphrey reviewing and commending the housing and urban development bill. pp. 16660-1
10. PUBLIC WORKS; FLOOD CONTROL. The Public Works Committee reported an original bill, S. 2300, to authorize the construction, repair, and preservation of certain public works on rivers and harbors for navigation, flood control, and other purposes (S. Rept. 464). p. 16646
11. DISASTER RELIEF. Passed over, at the request of Sen. Inouye, S. 1861, to provide additional assistance for areas suffering a major disaster. p. 16644

HOUSE

12. LEGISLATIVE BRANCH APPROPRIATION BILL, 1966. Conferees were appointed on this bill, H. R. 8775, which includes items for the Government Printing Office and the Library of Congress (pp. 16553-5). Senate conferees have already been appointed.
13. SALINE-WATER; RESEARCH. Conferees were appointed on S. 24, to expand, extend, and accelerate the saline water conversion program conducted by Interior (p. 16555). Senate conferees have already been appointed.

Johnson would name to fill the post. For the moment, Francis T. P. Plimpton, Stevenson's second in command, would step up. But the President would have to move soon to name a permanent replacement for the man who had brought so much prestige to the post.

Whoever the choice might fall upon, one thing was certain: The most able advocate of American policies—even those with which he was not in full accord—was lost to his Nation last Wednesday.

[From the Washington (D.C.) Star,
July 18, 1965]

HE LEFT BEHIND A MARKED PAGE ON HIS
BEDSIDE TABLE

(By Betty Beale)

For those of us who admired and loved Adlai Stevenson it is not easy to say goodbye.

He was such a unique, towering figure on the scenes chronicled on these pages. His great vitality of intellect, heart, soul and wit had an electric effect on every gathering he attended.

The picture of him as a lonely, frequently gloomy man, as portrayed in the Ben Shahn sketch on the cover of Time in December 1962, was for his intimate friends a totally false one.

He was a blithe spirit that delighted in so many things—an active useful life, the beauty of art, music and poetic words, humor wherever it might be found, and the kindnesses of people, big and little, scores of whom were so deeply devoted to him he had no time for loneliness.

Indeed, the social demands on his time were so much greater than the possibility of fulfillment he not infrequently became involved in two engagements the same evening in different cities.

His housekeeper, Violet Ready, who served his family during his mother's lifetime and was with him all the time he was U.N. Ambassador, could find no basis for the gloomy portrayal. He loved people, he had them around him all the time, and he kept up a personal correspondence with dozens more. If the tragedies of his personal life or the turn of world events depressed him at times, he quickly rose about them.

Indeed his sense of humor gave him a much gayer outlook on life than the average man's. Nor did his wit depend on speechwriters, as is so often the case with public men. There was that unforgettable time at a party for Lady Astor on her last visit to Washington when she said to him:

"You need me. I'm a rich widow."

And he immediately whipped back:

"I'm looking for somebody more mature."

He could even jest about Russia's hostility, although the strain of continuously coping with it is what really took his life. The night he took Soviet Ambassador and Mrs. Dobrynin to the Bolshoi Ballet opening in New York the Russian envoy was telling how his wife took pictures of sunsets everywhere she went in the United States.

"The picture of dying America, I suppose," was Adlai's amused comment.

Anyone who watched him at social gatherings soon became aware that he had but one manner toward all. It was the manner of grace and ease and warmth, and it came to him as naturally as breathing.

He was never rude or brusque with people, never impatient with boredom, though he was frequently detained by people he would gladly have escaped. He didn't think he was so important he could offend others.

It was perhaps this humility as much as anything that kept him from becoming President. As someone recently said: "You have to have ego to become President"—to think you are better qualified than all other men to run the country.

That is why it took a draft to get him in the race in 1962.

About a year ago he told this writer that Bobby Kennedy had come to him asking for his support of his brother at the Democratic convention in 1960 and offering him the Vice Presidency if he would nominate Jack Kennedy for President.

"I would be President today," he observed thoughtfully, but he had given his word to Johnson, he said, that he would remain neutral and not come out for either candidate.

On the incident of the much discussed selection by Kennedy of a running mate, Stevenson threw this light some time ago.

"Jack Kennedy called me early the morning after his nomination and said he wanted to come and talk to me. I told him that I would come to him and I got dressed and went over right away. He asked me what I thought about Lyndon Johnson for Vice President."

Stevenson told him that he thought it would heal the breach in the Democratic Party, that Johnson would help win the South and that he would be of enormous assistance in dealing with the Congress.

"But," he added, "of course, he won't take it."

He was surprised when Johnson did.

It is hard to believe that Stevenson said, as has been reported, that our Santo Domingo policy was "a massive blunder from beginning to end." Six weeks ago he said only that this country's mistake was in not waiting 24 hours to present our plan to the OAS. The 24-hour wait would not have been detrimental and would have given our position strength and support.

That Stevenson was feeling the strain of a 17-hour day almost every day in the week was apparent in recent months by his comments, not by any evidence of mental fatigue. Associates said that no matter how tired he might be physically, his mind always functioned at top lucidity.

He told the Roosevelt family last January that he would have to resign from the chairmanship of the Eleanor Roosevelt Foundation because it was killing him to try to do a good job with that along with everything else he had to do.

It is nice to know that he had a rare weekend with his grandchildren at his farm in Libertyville 10 days before his passing. After "a whirlpool for months," he called it "a quiet eddy" with "only six children under 14 and underfoot."

When he took off for Geneva he left behind on the bedside table in his New York apartment a printed page that he had marked.

Perhaps it was intended for a commencement address. It was not written by him but that he chose it and saved it for his attention upon his return is indicative of his own thought. It was entitled "Desiderata," and it was found in old St. Paul's Church, Baltimore, dated 1692.

He once said, "You cannot pluck out the mystery of the human heart." But perhaps this gives more insight into the mystery of his:

"Go placidly amid the noise and the haste and learn what peace there may be in silence * * *. Speak your truth quietly and clearly; and listen to others, even the dull and ignorant; they, too, have their story. * * * If you compare yourself with others you may become vain and bitter; for always there will be greater and lesser persons than yourself.

"Enjoy your achievements as well as your plans. Keep interested in your career, however humble; it is a real possession in the changing fortunes of time. Exercise caution in your business affairs; for the world is full of trickery. But let this not blind you to what virtue there is; many persons strive for high ideals; and everywhere life is full of heroism.

"Be yourself. Especially do not feign af-

fection. Neither be cynical about love; for in the face of all aridity and disenchantment it is as perennial as the grass. Take kindly the counsel of the years, gracefully surrendering the things of youth. Nurture strength of spirit to shield you in sudden misfortune. But do not distress yourself with imaginings. Many fears are born of fatigue and loneliness. Beyond a wholesome discipline, be gentle with yourself. You are a child of the universe no less than the trees and the stars; you have a right to be here. And whether or not it is clear to you no doubt the universe is unfolding as it should.

"Therefore, be at peace with God, whatever you conceive Him to be. And whatever your labors and aspirations in the noisy confusion of life keep peace with your soul. With all its sham, drudgery, and broken dreams, it is still a beautiful world."

[From the Sioux Falls (S. Dak.) Argus-Leader, July 15, 1965]

STEVENSON'S RICH LEGACY

As twice a candidate for the Presidency, Adlai Stevenson never won the majority of the American people. But he did win a warm place in the hearts of the citizens. Even those who disagreed sharply with his policies respected his sincerity, his good purpose and his eager desire to be of service.

He was a man of charm—a gentleman in the real sense of the word. He also was a citizen of integrity and character, able and willing to speak vigorously in defense of that in which he believed.

His life was dedicated in the main to public service both in his home State of Illinois and in the Nation. He became a broad student of world affairs and many in Washington respected deeply his profound understanding of the international problems and his intense and earnest effort to promote peace.

Many of his critics felt he was too much of an idealist, too much of a dreamer. But surely the Nation requires in high places some persons of prominence whose thoughts are unfettered by tradition and who can turn their eyes toward objectives difficult to achieve.

Perhaps Stevenson was too ready to expect extreme accomplishments. Yet all of us were enriched by the program he laid out and the goals he had in mind.

By any and all standards, he is to be remembered as one of America's good citizens—one of the best.

Mr. MONTROYA. Mr. President, I was out of the country at the Parliamentary Conference in Lima, Peru, when the shocking news of Ambassador Stevenson's death reached me.

I am deeply sorry that I was unable to return in time to attend the memorial services, but on the other hand I feel confident, that he, of all the men I know, would have understood.

American foreign policy was the subject nearest and dearest to his heart. Adlai Stevenson understood the importance of face-to-face meetings such as the one in Lima to the achievement of our goal of improved relations among nations.

He carried his heavy responsibilities with unflinching wit and verve and dedication. Under other circumstances, he would have led this Nation as well as serving as one of the chief exponents of her foreign policy.

But even if he had achieved the supreme gift of office which this country's citizens can bestow upon a man, I doubt that he could have been any more effec-

tive an advocate of our Nation's constant goal of a decent peaceful life for all the people of this world.

That he made this case with remarkable skill and clarity is shown by the admiration, and even reverence, in which he is held in other countries.

Like few other statesmen, Adlai Stevenson exemplified to the world the best that is in this country.

He will be sorely missed.

ORDER OF BUSINESS

The PRESIDING OFFICER. Is there further morning business? If not, morning business is closed.

COLD WAR VETERANS' READJUSTMENT ASSISTANCE ACT

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the unfinished business be laid before the Senate.

The PRESIDING OFFICER. The clerk will state the bill by title.

The LEGISLATIVE CLERK. A bill (S. 9) to provide readjustment assistance to veterans who serve in the Armed Forces during the induction period.

The PRESIDING OFFICER. Is there objection to the request of the Senator from Montana?

There being no objection, the Senate resumed the consideration of the bill.

Mr. MANSFIELD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. YARBOROUGH. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT OF CERTAIN PROVISIONS OF PUBLIC HEALTH SERVICE ACT RELATING TO CONSTRUCTION OF HEALTH RESEARCH FACILITIES

The PRESIDING OFFICER laid before the Senate a message from the House of Representatives announcing its disagreement to the amendment of the Senate to the bill (H.R. 2984) to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes, and requesting a conference with the Senate on the disagreeing votes of the two Houses thereon.

Mr. HILL. I move that the Senate insist upon its amendment and agree to the request of the House for a conference, and that the Chair appoint the conferees on the part of the Senate.

The motion was agreed to; and the Presiding Officer appointed Mr. HILL, Mr. YARBOROUGH, Mr. WILLIAMS of New Jersey, Mr. PELL, Mr. KENNEDY of Massachusetts, Mr. JAVITS, and Mr. MURPHY conferees on the part of the Senate.

PERSONNEL FOR COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

The PRESIDING OFFICER laid before the Senate a message from the House of Representatives announcing its disagreement to the amendments of the Senate to the bill (H.R. 2985) to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers, and requesting a conference with the Senate on the disagreeing votes of the two Houses thereon.

Mr. HILL. I move that the Senate insist upon its amendments and agree to the request of the House for a conference, and that the Chair appoint the conferees on the part of the Senate.

The motion was agreed to; and the Presiding Officer appointed Mr. HILL, Mr. YARBOROUGH, Mr. WILLIAMS of New Jersey, Mr. PELL, Mr. KENNEDY of Massachusetts, Mr. JAVITS, and Mr. MURPHY conferees on the part of the Senate.

EXTENSION AND AMENDMENT OF CERTAIN PROVISIONS OF THE PUBLIC HEALTH SERVICE ACT

The PRESIDING OFFICER laid before the Senate the amendment of the House of Representatives to the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes which was, to strike out all after the enacting clause and insert:

That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "June 30, 1965" and by inserting "and each of the next three fiscal years," immediately after "June 30, 1965." The second sentence of such subsection is amended by striking out "the fiscal years ending June 30, 1963, and June 30, 1964" and inserting in lieu thereof "any fiscal year ending prior to July 1, 1968". The third sentence of such subsection is amended by striking "and tetanus" and inserting in lieu thereof "tetanus, and measles", and by striking out "under the age of five years" and inserting in lieu thereof "of preschool age".

(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future."

(c) Subsection (b) of such section is amended by striking out "of limited duration", by striking out "against poliomyelitis, diphtheria, whooping cough, and tetanus" and inserting in lieu thereof "against the diseases referred to in subsection (a)", and by striking out "who are under the age of five years" and inserting in lieu thereof "of preschool age".

(d) (1) Such section is further amended by striking out "intensive community vaccination" wherever it appears in subsec-

tions (a), (b), and (c) and inserting in lieu thereof "immunization".

(2) The heading of such section is amended by striking out "INTENSIVE VACCINATION" and inserting in lieu thereof "IMMUNIZATION".

MIGRATORY WORKERS HEALTH SERVICES

SEC. 3. Section 310 of the Public Health Service Act is amended by striking out "the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965" and inserting in lieu thereof "each fiscal year ending prior to July 1, 1968".

GENERAL PUBLIC HEALTH SERVICES

SEC. 4. The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

Mr. HILL. Mr. President, I move that the Senate disagree to the amendment and request a conference with the House thereon, and that the Chair appoint the conferees on the part of the Senate.

The motion was agreed to; and the Presiding Officer appointed Mr. HILL, Mr. YARBOROUGH, Mr. WILLIAMS of New Jersey, Mr. PELL, Mr. KENNEDY of Massachusetts, Mr. JAVITS, and Mr. MURPHY conferees on the part of the Senate.

Mr. YARBOROUGH. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. YARBOROUGH. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

COLD WAR VETERANS' READJUSTMENT ASSISTANCE ACT

The Senate resumed the consideration of the bill (S. 9) to provide readjustment assistance to veterans who serve in the Armed Forces during the induction period.

The PRESIDING OFFICER. The clerk will state the committee amendment.

The LEGISLATIVE CLERK. On page 6 it is proposed to strike out line 7, as follows: "§ 1911. Duration of veteran's education or training

And insert in lieu thereof the following:

"§ 1910. Entitlement to education or training generally

The PRESIDING OFFICER. The question is on agreeing to the committee amendment.

The amendment was agreed to.

Mr. YARBOROUGH. Mr. President, I have received a letter in support of S. 9 from the State of California, signed by H. E. Summers, chief, bureau of readjustment education, department of education, dated July 14, 1965. It reads as follows:

July 23, 1965

15. HOUSING LOANS. Received the conference report on H. R. 7984, the housing and urban development bill (H. Rept. 679)(pp. 17415-37). Title X of the bill would provide a new \$300,000,000-per-year program of insured housing loans under the Farmers Home Administration in rural areas.
16. FORESTRY. The Subcommittee on Forests of the Agriculture Committee voted to report to the full committee H. R. 9161, with amendment, to authorize the acquisition of certain lands within the Unita National Forest, Utah; and S. 1689, with amendment, to provide additional authority for the Forest Service to rent property from its employees at isolated locations. p. D693
17. WATERSHEDS. The "Daily Digest" states that the Subcommittee on Conservation and Credit of the Agriculture Committee "approved several pending watershed projects." p. D693
18. HEALTH. Received the conference report on S. 510, to extend and amend certain expiring provisions of the Public Health Service Act relating to community health services (H. Rept. 676)(pp. 17413-4). As reported the bill extends for three years, until June 30, 1968, the program of health services to domestic agricultural migratory workers, and includes specific authorization for necessary short-term hospital care for such workers and their families.

ITEMS IN APPENDIX

19. FARM LABOR. Rep. Leggett inserted an agreement by the Tomato Growing Industry Council designed to produce \$1.75 per hour for qualified tomato pickers. p. A4018
20. SMALL BUSINESS. Sen. Randolph inserted Eugene P. Foley's speech emphasizing varied contributions of the Small Business Administration programs in strengthening the national economy. pp. A4019-21
21. PATENTS. Extension of remarks of Rep. Reuss stressing the need for revision of copyright laws and inserting excerpts of statements made by witnesses on the opening day of hearings before the House Judiciary Committee. pp. A4021-2
22. WATER SUPPLY. Extension of remarks of Rep. Roybal stressing the need for long-range planning to provide an adequate supply of water and inserting an article announcing the possible feasibility of constructing what would be the largest nuclear-fueled combination sea water conservation and power-producing plant in the world. pp. A4023-4
Rep. Roybal inserted the introductory chapter of the 1965 report on the Calif. State water project. pp. A4030-2
23. BREAD. Rep. Moss inserted an article, "High Bread Cost Laid to Processing." pp. A4028-9

BILLS INTRODUCED

24. LANDS. S. 2321 by Sen. Jackson, to amend the act of August 31, 1964 (78 Stat. 751), relating to the satisfaction of scrip and similar rights to Interior and Insular Affairs Committee. Remarks of author 17368-9

25. RESEARCH ANIMALS. S. 2322 by Sen. Magnuson, to authorize the Secretary of Agriculture to regulate the transportation, sale, and handling of dogs and cats intended to be used for purposes of research or experimentation; to Commerce Committee.
26. PATENTS. S. 2326 by Sen. Dirksen, to establish a uniform national policy concerning proprietary rights in inventions made through the expenditure of public funds; to Judiciary Committee. Remarks of author p. 17369

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COMMITTEE HEARINGS:

- July 26: Marketing order for table eggs, H. Agriculture.
Sale of Colville Indian lands, Wash., H. Interior.
Retirement of capital in Federal intermediate credit banks, S. Agriculture (exec).
- July 28: Proposed Spruce Knob-Seneca Rocks recreation area, W. Va., H. Agriculture (Nelson, FS, to testify).

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COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965

JULY 23, 1965.—Ordered to be printed

Mr. HARRIS, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany S. 510]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "June 30, 1965" and by inserting "and each of the next three fiscal years," immediately after "June 30, 1965,". The second sentence of such subsection is amended by striking out "the fiscal years ending June 30, 1963, and June 30, 1964" and inserting in lieu thereof "any fiscal year ending prior to July 1, 1968". The third sentence of such subsection is amended by striking "and tetanus" and inserting in lieu thereof "tetanus, and measles", and by striking out "under the age of five years" and inserting in lieu thereof "of preschool age".

(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "Such grants may also be used to pay similar costs in connection with immunization programs against

any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future."

(c) Subsection (b) of such section is amended by striking out "of limited duration", by striking out "against poliomyelitis, diphtheria, whooping cough, and tetanus" and inserting in lieu thereof "against the diseases referred to in subsection (a)", and by striking out "who are under the age of five years" and inserting in lieu thereof "of preschool age".

(d)(1) Such section is further amended by striking out "intensive community vaccination" wherever it appears in subsections (a), (b), and (c) and inserting in lieu thereof "immunization".

(2) The heading of such section is amended by striking out "INTENSIVE VACCINATION" and inserting in lieu thereof "IMMUNIZATION".

(e) Paragraph (1) of subsection (c) is amended by inserting "on the basis of estimates" after "advance"; by striking out the comma after the word "reimbursement" and inserting in lieu thereof "(with necessary adjustments on account of underpayments or overpayments)".

MIGRATORY WORKERS HEALTH SERVICES

SEC. 3. (a) Section 310 of the Public Health Service Act is amended by striking out "for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed \$3,000,000 for any year, as may be necessary" and inserting in lieu thereof "not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, and \$9,000,000 for the fiscal year ending June 30, 1968".

(b) Such section is further amended by inserting "including necessary hospital care, and" immediately after "agricultural migratory workers and their families," in clause (1)(ii) of such section.

GENERAL PUBLIC HEALTH SERVICES

SEC. 4. (a) The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

(b) The third sentence of subsection (c) of section 314 of such Act is amended by striking out "\$2,500,000" and inserting in lieu thereof "\$5,000,000".

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

SEC. 5. *The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".*

And the House agree to the same.

OREN HARRIS,
LEO W. O'BRIEN,
PAUL G. ROGERS,
DAVID E. SATTERFIELD III,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,
Managers on the Part of the House.

LISTER HILL,
RALPH W. YARBOROUGH,
HARRISON WILLIAMS,
CLAIBORNE PELL,
EDWARD KENNEDY,
J. JAVITS,
GEORGE L. MURPHY,
Managers on the Part of the Senate.

STATEMENT OF THE MANAGERS ON THE PART OF THE HOUSE

The managers on the part of the House at the conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, submit the following statement in explanation of the effect of the action agreed upon by the conferees and recommended in the accompanying conference report:

The amendment of the House to the Senate bill was a substitute for the entire text of the Senate bill. The conference agreement is a substitute for both the House bill and the Senate text. Except with respect to technical, clerical, clarifying, and conforming changes, the differences between the conference substitute and the House amendment are set forth below.

IMMUNIZATION PROGRAMS

The House amendment provided a 3-year extension at an annual authorization ceiling of \$11,000,000 of the existing programs of immunization against poliomyelitis, diphtheria, whooping cough, and tetanus; and provided authority for immunization against measles and also against other diseases of an infectious nature which the Surgeon General finds represent a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and which he finds are susceptible of practical elimination as a public health problem through immunization with preventive agents which may become available in the future. The conference substitute is the same in this regard as the House amendment.

The Senate version of the bill permitted advance payments (with necessary adjustments on account of underpayments or overpayments) to the States and local agencies carrying out immunization programs, on the basis of estimates of the numbers of children eligible to participate in the program, and modified the necessity of keeping certain records. The House amendment contained no similar provision. The conference substitute permits advance payments on the basis of estimates (with necessary adjustments on account of underpayments or overpayments). The conference substitute does not include the provisions relating to modified recordkeeping; however, in view of the conference substitute and in view of the language already in the act which authorizes grants for costs "reasonably attributable" to protecting the eligible age group, the conferees expect that the Surgeon General will review with the States and local agencies affected methods for simplifying recordkeeping requirements under this program, so as to eliminate unnecessary paperwork.

DOMESTIC AGRICULTURAL MIGRATORY WORKERS HEALTH SERVICES

The Senate bill extended for 5 years the current program whereby health services are provided for domestic agricultural migratory workers, expanded the program to specifically include necessary hospital care, and authorized appropriations aggregating \$44,000,000 over the 5-year period.

The House amendment provided a straight 3-year extension of the existing program, at the current \$3,000,000 a year authorization level.

The conference agreement limits the extension of the program to 3 years, and authorizes appropriations not to exceed \$7,000,000 for fiscal year 1966, \$8,000,000 for fiscal year 1967, and \$9,000,000 for fiscal year 1968.

The conference agreement also includes specific authorization for necessary short-term hospital care for domestic agricultural migratory workers and their families which was in the Senate bill but not in the House amendment. It is the intention of the conferees that this authority for hospital care will be utilized on a limited basis, in accordance with priorities established by the Surgeon General on the basis of the demonstrated need of patients, and that reimbursement to hospitals for the care provided will be primarily directed to those hospitals on which a hardship would be worked if reimbursement were not provided.

SCHOOLS OF PUBLIC HEALTH

Both the House amendment and the Senate bill provided a 1-year extension of the existing program of grants to the States for health services under section 314(c) of the Public Health Service Act, in order to provide time for a complete review of the program currently being conducted under this section.

The Senate bill increased the current \$2,500,000 annual authorization for grants-in-aid to schools of public health to \$5,000,000. The House amendment contained no similar provision.

The conference substitute is the same as the Senate version. The managers on the part of the House were impressed with the fact that programs established under the Graduate Public Health Training Amendments of 1964 have provided an increased burden on the schools of public health, and the increased authorization is necessary in order to meet the needs of the schools today. This does not, of course, increase the overall authorization under section 314(c), which remains at \$50,000,000 a year.

OREN HARRIS,
LEO W. O'BRIEN,
PAUL G. ROGERS,
DAVID E. SATTERFIELD III,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,
Managers on the Part of the House.

House of Representatives

FRIDAY, JULY 23, 1965

The House was not in session today. Its next meeting will be held on Monday, July 26, 1965, at 12 o'clock noon.

COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965

Pursuant to an order of the House on Thursday, July 22, 1965, the conference report on the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, is herewith printed as follows:

[Submitted by Mr. HARRIS]

CONFERENCE REPORT (H. REPT. NO. 676)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House and agree to the same with an amendment as follows: In lieu of the matter proposed to be inserted by the House amendment insert the following: "That this Act may be cited as the 'Community Health Services Extension Amendments of 1965'."

"IMMUNIZATION PROGRAMS"

"SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out 'and' before 'June 30, 1965' and by inserting 'and each of the next three fiscal years,' immediately after 'June 30, 1965.' The second sentence of such subsection is amended by striking out 'the fiscal years ending June 30, 1963, and June 30, 1964' and inserting in lieu thereof 'any fiscal year ending prior to July 1, 1968'. The third sentence of such subsection is amended by striking 'and tetanus' and inserting in lieu thereof 'tetanus, and measles', and by striking out 'under the age of five years' and inserting in lieu thereof 'of preschool age'.

"(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: 'Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future.'

"(c) Subsection (b) of such section is amended by striking out 'of limited duration', by striking out 'against poliomyelitis, diphtheria, whooping cough, and tetanus' and inserting in lieu thereof 'against the diseases referred to in subsection (a)', and by striking out 'who are under the age of five years' and inserting in lieu thereof 'of preschool age'.

"(d) (1) Such section is further amended by striking out 'intensive community vac-

cination' wherever it appears in subsections (a), (b), and (c) and inserting in lieu thereof 'immunization'.

"(2) The heading of such section is amended by striking out 'INTENSIVE VACCINATION' and inserting in lieu thereof 'IMMUNIZATION'.

"(e) Paragraph (1) of subsection (c) is amended by inserting 'on the basis of estimates' after 'advance'; by striking out the comma after the word 'reimbursement' and inserting in lieu thereof '(with necessary adjustments on account of underpayments or overpayments)'.

"MIGRATORY WORKERS HEALTH SERVICES"

"SEC. 3. (a) Section 310 of the Public Health Service Act is amended by striking out 'for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed \$3,000,000 for any year, as may be necessary' and inserting in lieu thereof 'not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, and \$9,000,000 for the fiscal year ending June 30, 1968'.

"(b) Such section is further amended by inserting 'including necessary hospital care, and' immediately after 'agricultural migratory workers and their families,' in clause (1) (ii) of such section.

"GENERAL PUBLIC HEALTH SERVICES"

"SEC. 4. (a) The first sentence of subsection (c) of section 314 of such Act is amended by striking out 'first five fiscal years ending after June 30, 1961' and inserting in lieu thereof 'first six fiscal years ending after June 30, 1961'.

"(b) The third sentence of subsection (c) of section 314 of such Act is amended by striking out '\$2,500,000' and inserting in lieu thereof '\$5,000,000'.

"SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES"

"SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out 'first five fiscal years ending after June 30, 1961' and inserting in lieu thereof 'first six fiscal years ending after June 30, 1961'.

And the House agree to the same.

OREN HARRIS,
LEO W. O'BRIEN,
PAUL G. ROGERS,
DAVID E. SATTERFIELD,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,

Managers on the Part of the House.

LISTER HILL,
RALPH W. YARBOROUGH,
HARRISON WILLIAMS,
CLAIBORNE PELL,
EDWARD KENNEDY,
JACOB JAVITS,
GEORGE MURPHY,

Managers on the Part of the Senate.

STATEMENT

The managers on the part of the House at the conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to

community health services, and for other purposes, submit the following statement in explanation of the effect of the action agreed upon by the conferees and recommended in the accompanying conference report:

The amendment of the House to the Senate bill was a substitute for the entire text of the Senate bill. The conference agreement is a substitute for both the House bill and the Senate text. Except with respect to technical, clerical, clarifying, and conforming changes, the differences between the conference substitute and the House amendment are set forth below.

IMMUNIZATION PROGRAMS

The House amendment provided a 3-year, at an annual authorization ceiling of \$11,000,000, extension of the existing programs of immunization against poliomyelitis, diphtheria, whooping cough, and tetanus; and provided authority for immunization against measles and also against other diseases of an infectious nature which the Surgeon General finds represent a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and which he finds are susceptible of practical elimination as a public health problem through immunization with preventive agents which may become available in the future. The conference substitute is the same in this regard as the House amendment.

The Senate version of the bill permitted advance payments (with necessary adjustments on account of underpayments or overpayments) to the States and local agencies carrying out immunization programs, on the basis of estimates of the numbers of children eligible to participate in the program, and modified the necessity of keeping certain records. The House amendment contained no similar provision. The conference substitute permits advance payments on the basis of estimates (with necessary adjustments on account of underpayments or overpayments). The conference substitute does not include the provisions relating to modified recordkeeping; however, in view of the conference substitute and in view of the language already in the act which authorizes grants for costs "reasonably attributable" to protecting the eligible age group, the conferees expect that the Surgeon General will review with the States and local agencies affected methods for simplifying recordkeeping requirements under this program, so as to eliminate unnecessary paperwork.

DOMESTIC AGRICULTURAL MIGRATORY WORKERS HEALTH SERVICES

The Senate bill extended for 5 years the current program whereby health services are provided for domestic agricultural migratory workers, expanded the program to specifically include necessary hospital care, and authorized appropriations aggregating \$44,000,000 over the 5-year period.

The House amendment provided a straight 3-year extension of the existing program, at the current \$3,000,000-a-year authorization level.

The conference agreement limits the extension of the program to 3 years, and authorizes appropriations not to exceed \$7,000,000 for fiscal year 1966, \$8,000,000 for fiscal year 1967, and \$9,000,000 for fiscal year 1968.

The conference agreement also includes specific authorization for necessary short-term hospital care for domestic agricultural migratory workers and their families which was in the Senate bill but not in the House amendment. It is the intention of the conferees that this authority for hospital care will be utilized on a limited basis, in accordance with priorities established by the Surgeon General on the basis of the demonstrated need of patients, and that reimbursement to hospitals for the care provided will be primarily directed to those hospitals on which a hardship would be worked if reimbursement were not provided.

SCHOOLS OF PUBLIC HEALTH

Both the House amendment and the Senate bill provided a 1-year extension of the existing program of grants to the States for health services under section 314(c) of the Public Health Service Act, in order to provide time for a complete review of the program currently being conducted under this section.

The Senate bill increased the current \$2,500,000 annual authorization for grants-in-aid to schools of public health to \$5,000,000. The House amendment contained no similar provision.

The conference substitute is the same as the Senate version. The managers on the part of the House were impressed with the fact that programs established under the Graduate Public Health Training Amendments of 1964 have provided an increased burden on the schools of public health, and the increased authorization is necessary in order to meet the needs of the schools today. This does not, of course, increase the overall authorization under section 314(c), which remains at \$50,000,000 a year.

OREN HARRIS,
LEO W. O'BRIEN,
PAUL G. ROGERS,
DAVID E. SATTERFIELD,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,

Managers on the Part of the House.

HEALTH RESEARCH FACILITIES AMENDMENTS OF 1965

Pursuant to an order of the House on Thursday, July 22, 1965, the conference report on the bill (H.R. 2984) to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes, is herewith printed as follows:

[Submitted by Mr. HARRIS]

CONFERENCE REPORT (H. REPT. NO. 677)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2984) to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows: In lieu of the matter proposed to be inserted by the Senate amendment insert the following: "That this Act may be cited as the 'Health Research Facilities Amendments of 1965'."

"HEALTH RESEARCH FACILITIES CONSTRUCTION GRANTS

"SEC. 2. (a) Section 704 of the Public Health Service Act (hereinafter referred to as the 'Act') is amended by inserting after '\$50,000,000,' the following: 'and for the fiscal year ending June 30, 1967, and the two succeeding fiscal years, an aggregate of not to exceed \$280,000,000,'."

"(b) Subsection (a) of section 705 of the Act is amended by striking out 'June 30, 1965' and inserting in lieu thereof 'June 30, 1968'."

"CONTRACT AUTHORITY

"SEC. 3. Section 301 of the Act is amended by striking out 'and' at the end of subsection (g), by redesignating subsection (h) as subsection (i), and by inserting immediately before such subsection the following new subsection:

"(h) Enter into contracts during the fiscal year ending June 30, 1966, and each of the two succeeding fiscal years, including contracts for research in accordance with and subject to the provisions of law applicable to contracts entered into by the military departments under title 10, United States Code, sections 2353 and 2354, except that determination, approval, and certification required thereby shall be by the Secretary of Health, Education, and Welfare; and'."

"ADDITIONAL ASSISTANT SECRETARIES OF HEALTH, EDUCATION, AND WELFARE

"SEC. 4. (a) There shall be in the Department of Health, Education, and Welfare, in addition to the Assistant Secretaries now provided for by law, three additional Assistant Secretaries of Health, Education, and Welfare, who shall be appointed by the President, by and with the advice and consent of the Senate. The provisions of section 2 of the Reorganization Plan Numbered 1 of 1953 (67 Stat. 631) shall be applicable to such additional Assistant Secretaries to the same extent as they are applicable to the Assistant Secretaries authorized by that section.

(b) The office of Special Assistant to the Secretary (Health and Medical Affairs), created by section 3 of the Reorganization Plan Numbered 1 of 1953 (67 Stat. 631), is hereby abolished.

"(c) Paragraph (17) of section 303(d) of the Federal Executive Salary Act of 1964 (78 Stat. 418) is amended by striking out '(2)' before the period at the end thereof and inserting in lieu thereof '(5)'; and paragraph (95) of section 303(e) of such Act is repealed.

"(d) The President may authorize the person who immediately prior to the date of enactment of this Act occupies the office of Special Assistant to the Secretary (Health and Medical Affairs) to act as one of the additional Assistant Secretaries authorized by subsection (a) of this section, until that office is filled by appointment in the manner provided by such section. While so acting, such person shall receive compensation at the rate now or hereafter provided by law for Assistant Secretaries of executive departments."

And the Senate agree to the same.

OREN HARRIS,
LEO W. O'BRIEN,
PAUL G. ROGERS,
DAVID E. SATTERFIELD,
JAMES A. MACKAY,
JOHN J. GILLIGAN,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,

Managers on the Part of the House.

LISTER HILL,
RALPH W. YARBOROUGH,
HARRISON WILLIAMS,
CLAIBORNE PELL,
EDWARD KENNEDY,
JACOB JAVITS,
GEORGE L. MURPHY,

Managers on the Part of the Senate.

STATEMENT

The managers on the part of the House at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2984) to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes, submit the following statement in explanation of the effect of the action agreed upon by the conferees and recommended in the accompanying conference report:

The amendment of the Senate is a complete substitute for the text of the House bill, which differed from the House bill in only two respects, discussed hereafter. The conference substitute is a substitute for both the House bill and the Senate amendment.

SPECIALIZED REGIONAL OR NATIONAL FACILITIES

The Senate amendment provided authority for nonmatching grants for construction and operation of regional or national facilities for the conduct of research, or for research and related purposes, with 4-year authorization of appropriations aggregating \$35,000,000. The conference agreement deletes this authorization. It is expected that the scope of regional and national research programs will be studied in connection with other legislation.

CONTRACT AUTHORITY

The House bill authorized the Surgeon General to carry out his responsibilities under section 301 of the Public Health Service Act by entering into contracts, including contracts for research subject to the provisions of law applicable to the military departments, subject to an overall ceiling of \$43,000,000 for any one fiscal year, with a 3-year authorization. The Senate amendment provided the same authority, but deleted both the limitation as to time and the limitation as to obligational authority. Similar authority has been provided heretofore by "point-of-order" language contained annually in appropriation acts.

The conference agreement retains the 3-year limitation contained in the House amendment, but deletes the ceiling on obligational authority. Of course, the 3-year limitation applies only to the duration of the authority to enter into contracts, and does not limit the duration of the contracts themselves. It is expected that the operations of the contract authority will be carefully reviewed when a request for the extension of this authority is made in the future.

In all other respects the conference substitute is identical to the House bill.

OREN HARRIS,
LEO W. O'BRIEN,
PAUL G. ROGERS,
DAVID E. SATTERFIELD,
JAMES A. MACKAY,
JOHN J. GILLIGAN,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,

Managers on the Part of the House.

MENTAL RETARDATION FACILITIES AND COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION ACT AMENDMENTS OF 1965

Pursuant to an order of the House on Thursday, July 22, 1965, the conference report on the bill (H.R. 2985) to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers, is herewith printed, as follows:

DIGEST of Congressional Proceedings

OF INTEREST TO THE DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C. 20250
OFFICIAL BUSINESS

POSTAGE AND FEES PAID
U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF BUDGET AND FINANCE
(FOR INFORMATION ONLY;
NOT TO BE QUOTED OR CITED)

Issued July 27, 1965
For actions of July 26, 1965
89th-1st; No. 135

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HIGHLIGHTS: Senate agreed to conference report on housing bill. Sen. Smith inserted letter critical of food stamp program. Sen. Aiken inserted Secretary Freeman's report to President on aid to drought-stricken areas. Sen. Tower commended passage of bill providing FHA loans and grants for rural water systems. Rep. Betts expressed concern over rising food costs. Rep. Hathaway defended rise in potato prices.

SENATE

1. **HOUSING LOANS.** Received and agreed to the conference report on H. R. 7984, the housing and urban development bill (pp. 17630-37). Title X of the bill would provide a new \$300,000,000-per-year program of insured housing loans under the Farmers Home Administration in rural areas.

2. FARM CREDIT. A subcommittee of the Agriculture and Forestry Committee "approved for full committee consideration with an amendment H. R. 4152, to provide for loans to production credit associations by Federal intermediate credit banks without the necessity of collateral." p. D698
3. HEALTH. Received and agreed to the conference report on S. 510, to extend and amend certain expiring provisions of the Public Health Service Act relating to community health services, which includes provisions extending until June 30, 1968, the program of health services to domestic agricultural migratory workers, and providing specific authorization for necessary short-term hospital care for such workers and their families. pp. 17598-9
4. LANDS. The Interior and Insular Affairs Committee reported with amendment S. 625, to authorize the sale of certain isolated or disconnected tracts of land (S. Rept. 512). p. 17555
5. RECLAMATION. The Interior and Insular Affairs Committee reported with amendment S. 1088, to authorize the construction of the Touchet division, Walla Walla project, Oregon-Washington (S. Rept. 511). p. 17555
6. PUBLIC LAW 480. Sen. Miller criticized Public Law 480 assistance to the United Arab Republic, and inserted excerpts from a GAO report stating that "U. S. commercial dollar sales of tallow to the United Arab Republic have been displaced by sales of surplus tallow for foreign currency under title I, Public Law 480, programs." p. 17643
Both Houses received a GAO report "on significant dollar savings available in financing foreign sales agents' commissions on surplus agricultural commodities exported" under title I, Public Law 480. pp. 17548, 17552
7. FOOD STAMPS. Sen. Smith inserted a letter from the welfare director of Portland, Me., critical of the administration of the food stamp program in that area. pp. 17569-70
8. DISASTER RELIEF. Sen. Aiken inserted a report by Secretary Freeman to the President reviewing steps being taken by this Department to provide aid to drought-stricken areas. p. 17569
9. LOANS. Sen. Tower commended provisions of S. 1766, recently passed by the Senate, which would authorize loans and grants by this Department to finance the development of rural water systems. p. 17578
10. FOREIGN AID; CCC. Sen. Simpson inserted an article, "Sleuth of the Senate," commending investigations conducted by Sen. Williams, Del., including references to the diversion of grain shipped to Austria under Public Law 480, and the purchase of soybean oil by CCC. pp. 17577-8
11. POVERTY. Sen. Murphy submitted an amendment to the Economic Opportunity Act which he stated "would bring the remaining VISTA volunteers and all persons employed on community action projects for private nonprofit organizations under the Hatch Act's prohibition on improper political activities"; to Labor and Public Welfare Committee. pp. 17562-3
12. NATIONAL ECONOMY. Sen. Hartke inserted an address by Vice President Humphrey before the National Conference of the American Society of Corporate Secretaries reviewing the status of the national economy. pp. 17591-3

suspicion. Appearances are often as important as events. Nothing dims the image of courts more than "interminable delays" in adjudication. It corrodes, as Chief Justice Warren said, the very foundation of justice. IMAGE OF JUSTICE DEPENDS ON LAWYERS, TOO

Moreover, the image of justice depends greatly upon the lawyers. I am sure that you businessmen who unfortunately may have been litigants understand. So many lawyers lay the loss of a case at the feet of the judge or the court. This is natural but is nothing short of a self-confession of error and a hopeful avoidance of responsibility. There are always two sides to a case. If clients corrected lawyers in such instances instead of joining in with the castigation of the courts it would be helpful. But I suppose that is asking too much.

Now what is the relevance of all this to a layman? What can he do to correct these long-existing deficiencies in our judicial system? The short answer is that nothing can be done without you. Experience in California, Colorado, Iowa, Illinois, Florida, North Carolina, and New York proves that much can be done with you. Without the support of an informed citizenry judicial reform cannot be attained. The lone plea of the lawyers and the judges for an adequate judicial system has always fallen on deaf political ears. Nothing talks as well as the voter. The operation of the courts is a local matter. If we are to have an efficient court system we must begin at the grass roots. Your active assistance is needed.

When you go back home check up on your judicial system. Ask your judge, your lawyer, your legislator, your newspaper editor. Find out where it can be improved. Then go to your local judge and propose to him that he organize a "law-laymen" committee to secure the needed improvement. On this committee have the leading citizens of your town and get your neighbor in the next town to do the same thing. Soon you will have an organization that can get the job done. Judge Bolitha Laws did just that in Washington, D.C., a decade or so ago. Now we have a beautiful courthouse, an efficient court system, and a modernized administration of justice.

Moreover, while you are here at this meeting why not appoint a national committee to coordinate your efforts with the organized professional associations that I have mentioned? The time is ripe for a stupendous national effort to improve the administration of justice.

As I close let me say again that this is an historic occasion. It is the first national call for laymen to work for more effective justice. No more important task could be undertaken. "Justice," said Webster, "is the greatest interest of man on earth." Let me add that they who work to strengthen its foundations shall forever be called blessed for only through the rule of law shall every man inherit the earth.

REPORT TO THE SENATE ON THE LATIN AMERICAN PARLIAMEN- TARY CONFERENCE HELD IN LIMA, PERU, JULY 14-18, 1965

Mr. MONTOYA. Mr. President, I spent an informative and rewarding 5 days in Lima, Peru, recently as the U.S. Senate's official observer at the second Latin American Parliamentary Conference.

I do not mind telling you that I approached this Conference with some trepidation, because I had been led to believe by press reports that there was widespread criticism in the Latin American countries of our very necessary deci-

sion to intervene in the Dominican Republic crisis 3 months ago.

You will be happy to know, Mr. President, that there was actually very little criticism of the United States at this Conference.

The nations which were official members of the Conference were Argentina, Brazil, Costa Rica, Chile, El Salvador, Honduras, Guatemala, Nicaragua, Panama, Peru, Uruguay, Venezuela, and Colombia. In addition, Trinidad and Jamaica were represented by observers, as we were.

There was some criticism expressed, but we were able to prevent the adoption of any resolutions inimical to the United States.

The day the conference opened, a delegate from Venezuela took the floor to denounce this country. But I knew many of the Venezuelan delegates, Mr. President, and it did not sound to me like this one individual was reflecting the views of the others.

That evening I called on every one of the other Venezuelan delegates and found that my suspicions were fully justified. None of that man's colleagues supported his position, and at my urging, each of them took the floor the next day to disavow what he had said.

If left to stand, his statement would have been a serious blow to U.S. prestige and would have been the door opener for further criticism against the United States.

Later on, a delegate from Uruguay introduced a resolution attacking the United States, but we were able to prevail on the Conference to turn it down.

As a result, Mr. President, the United States emerged from this meeting with more support and understanding of her role in the Dominican situation than she had before.

I want to give credit to our esteemed Ambassador, J. Wesley Jones, who assigned an able staff to work out a proper representation of our country at the Conference. Mr. James Haahr, first secretary at the U.S. Embassy in Lima, headed this team with great ability and dedication.

Although formal membership in the Parliamentary Conference is limited to Latin American countries, it should be emphasized that it is no sense an anti-U.S. group.

It is simply an expression of a widespread belief among the democratic Latin countries that they need their own organization to give a solidarity of effort and unanimity of approach to the problems of economic development, the fostering of democratic government, and social reform.

Because of my interest in Latin America, I have done all I can to foster new lines of communication wherever possible.

For example, the series of interparliamentary meetings which we have held with Mexico, our closest Latin neighbor, have proven of inestimable value to this country.

Before closing, Mr. President, I should like to say a few words about our host country for the Parliamentary Conference, Peru.

Peru will be one of the showcases of Latin American democracy in just a few short years. Under the leadership of President Fernando Belaunde, democratic government has been firmly established, and the country has made remarkable economic strides recently.

His government is aggressively attacking the Communists wherever they rear their heads. He has ordered the army and the police to round up those Communists who are trying to implant Castroism in the mountain areas. The liberal press has joined in this fight. The people are being alerted.

This is a good sign.

Unfortunately, President Belaunde's efforts at reform have been meeting violent resistance from Castro-trained Communists. Shortly before our conference began, guerrillas in the Peruvian mountains killed seven policemen in an ambush, and not long thereafter, two dynamite bombs were set off in downtown Lima. No one was killed, but there were serious injuries.

President Belaunde showed that he is determined to deal effectively with such subversion.

He has caused the arrest of a number of Castroist and other Communist leaders suspected of responsibility for this terrorism, and is making a determined effort to control the guerrilla menace.

I think, Mr. President, that the record in Peru is an indicator of the changes for the better which are occurring throughout Latin America.

It is a hopeful record, and one to which we, through conferences such as I have just described and through other programs, have made a substantial contribution.

MENTAL RETARDATION FACILITIES AND COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION ACT AMENDMENTS OF 1965—CONFERENCE REPORT

Mr. HILL. Mr. President, I submit a report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 2985) to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers. I ask unanimous consent for the present consideration of the report.

The PRESIDING OFFICER. The report will be read for the information of the Senate.

The legislative clerk read the report. (For conference report, see House proceedings of July 23, 1965, pp. 17417-17415, CONGRESSIONAL RECORD.)

The PRESIDING OFFICER. Is there objection to the present consideration of the report?

There being no objection, the Senate proceeded to consider the report.

Mr. HILL. Mr. President, H.R. 2985 as passed by the Senate and the House authorized the Secretary of Health, Education, and Welfare to pay part of the initial professional and technical staffing costs of community mental health centers. The Federal share could not

exceed 75 percent during the first 15 months, 60 percent during the next 12 months, 45 percent during the next 12 months, and 30 percent during the next 12 months. A total of 51 months of staffing assistance is authorized.

The Senate and the House approved appropriation authorizations of \$19,500,000 for fiscal year 1966, \$24 million for fiscal year 1967, and \$30 million for fiscal year 1968 to enable the Secretary to make initial grants to community mental health centers.

In the case of continuation grants the legislation authorizes such appropriations as may be necessary to complete the financing initiated in the fiscal years 1966, 1967, and 1968.

As passed by the House, however, H.R. 2985 did not provide for appropriations for continuation grants beyond fiscal year 1969. The Senate amendment authorized appropriations for continuation grants through fiscal year 1972 so that funds could be appropriated to finance the full 51 months of staffing assistance for all community mental health centers receiving initial grants in fiscal years 1966, 1967, 1968. The conferees accepted the Senate amendment.

The total 7-year cost for the new program is estimated at \$224,175,000.

In addition, the conferees agreed to extend for an additional 3 years the Public Law 88-164 programs for training teachers of handicapped children and for research and demonstrations in educating handicapped children.

The conferees approved appropriation authorizations totaling \$101 million for training teachers of handicapped children for the three fiscal years 1967-69.

The conferees also approved appropriation authorizations totaling \$35 million for research and demonstrations in educating handicapped children for the three fiscal years 1967-69 and an increase of \$4 million in the appropriation authorization for fiscal year 1966 to a total of \$6 million for that year. The conference agreement authorizes the construction and operation of a facility for research in the field of special education.

In closing, let me say that the approval of the conference agreement on H.R. 2985 will permit great progress in the care and treatment of the mentally ill and in the education of handicapped children.

The Members will recall that in 1963 we approved the legislation authorizing assistance in the construction of community mental health centers. That legislation in conjunction with the initial staffing assistance that H.R. 2985 would authorize will bring new hope to the mentally ill and to their families and friends. As community mental health centers are established across the country we will reduce the toll of mental illness and minimize the periods of institutional care.

H.R. 2985 would also strengthen our resources for educating children who are handicapped by mental retardation, deafness, blindness and other disabilities. We now need 300,000 teachers trained in special education, but we have only 60,000. If we are to offer handicapped children the opportunity for an adequate

education we need to increase our efforts in training teachers and in pursuing research and demonstrations that will improve educational methods.

The conference report is signed by all of the conferees on the part of the Senate and by all of the conferees on the part of the House.

Mr. President, I move the adoption of the report.

The PRESIDING OFFICER. The question is on agreeing to the conference report.

The report was agreed to.

HEALTH RESEARCH FACILITIES AMENDMENTS OF 1965—CONFERENCE REPORT

Mr. HILL. Mr. President, I submit a report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2984) to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes. I ask unanimous consent for the present consideration of the report.

The PRESIDING OFFICER. The report will be read for the information of the Senate.

The legislative clerk read the report. (For conference report, see House proceedings of July 23, 1965, p. 17414, CONGRESSIONAL RECORD.)

The PRESIDING OFFICER. Is there objection to the present consideration of the report?

There being no objection, the Senate proceeded to consider the report.

Mr. HILL. Mr. President, as passed by the Senate and House, H.R. 2984 authorizes a 3-year extension and appropriations aggregating \$280 million for the matching grant program of the Public Health Service for the construction of health research facilities.

A Senate amendment to H.R. 2984 authorized appropriations of \$35 million for grants to be awarded by the Public Health Service to pay for the costs of establishing health research facilities of national or regional importance. The conferees agreed to defer action on this new authority so that it could be considered by the House in connection with the legislation that would establish regional medical complexes to combat heart disease, cancer, and stroke.

As passed by the House, H.R. 2984 authorized the Surgeon General of the Public Health Service to enter into contracts, including contracts for research subject to certain provisions of law applicable to the military departments and subject to an overall ceiling of \$43 million on annual appropriations for the fiscal years 1966, 1967, and 1968. The conferees agreed to delete the \$43 million limitation on appropriations. This action of the conferees recognizes that many research activities can be pursued most effectively through contracts and through utilizing industrial capabilities.

It is clearly in the best public interest to allow the Public Health Service access to nongovernment capabilities through contracts as an alternative to duplicating existing resources and developing them as Federal activities.

Both the Senate and House approved the creation of three additional Assistant Secretaries in the Department of Health, Education, and Welfare.

The conference report is signed by all the conferees on the part of the Senate and by all of the conferees on the part of the House.

Mr. President, I move the adoption of the report.

The PRESIDING OFFICER. The question is on agreeing to the conference report.

The report was agreed to.

COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965—CONFERENCE REPORT

Mr. HILL. Mr. President, I submit a report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the bill—S. 510—to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes. I ask unanimous consent for the present consideration of the report.

The PRESIDING OFFICER. The report will be read for the information of the Senate.

The legislative clerk read the report.

(For conference report, see House proceedings of July 23, 1965, p. 17413, CONGRESSIONAL RECORD.)

The PRESIDING OFFICER. Is there objection to the present consideration of the report?

There being no objection, the Senate proceeded to consider the report.

Mr. HILL. Mr. President, the conferees agreed to the House amendment that authorized \$33 million over the 3 fiscal years 1966-68 to assist in financing immunization programs against polio, diphtheria, whooping cough, tetanus, and measles, in lieu of the 5-year program approved by the Senate. The Senate amendment relating to simplified record-keeping was accepted in a modified form.

There was agreement to authorize \$24 million in appropriations over the 3 fiscal years 1966-68 for health services for domestic agricultural farmworkers and their families. The Senate had approved \$44 million for the 5 fiscal years 1966-70 and the House of Representatives had approved \$9 million for the 3 fiscal years 1966-68. The House amendment deleting authorization for financing necessary hospital care was rejected.

There was also agreement to reject the House amendment that deleted the Senate-approved increase in the subceiling on appropriations from \$2,500,000 to \$5 million for formula grants for schools of public health for each of the fiscal years 1966 and 1967.

The provisions of the legislation authorizing \$50 million for formula grants for fiscal year 1967 for general health services, mental health services, dental

health services, health services for the chronically ill and aged, radiological health services, and schools of public health as well as \$10 million for project grants for community health services for fiscal year 1967 were identical as approved by the Senate and House of Representatives and were not in conference.

These programs of the Public Health Service are outstanding examples of Federal-State cooperation in advancing health in this country.

The conference report is signed by all of the conferees on the part of the Senate and by all the conferees on the part of the House.

Mr. President, I move the adoption of the report.

The PRESIDING OFFICER. The question is on agreeing to the conference report.

The report was agreed to.

The PRESIDING OFFICER. Is there further morning business? If not, morning business is closed.

NATIONAL AMERICAN LEGION BASEBALL WEEK—LEGISLATIVE REAPPORTIONMENT

Mr. MANSFIELD. Mr. President, I ask unanimous consent that the unfinished business be laid before the Senate.

The PRESIDING OFFICER. The Senate joint resolution will be stated by title.

The LEGISLATIVE CLERK. A joint resolution (S.J. Res. 66) to provide for the designation of the period from August 31 through September 6, 1965, as National American Legion Baseball Week.

The PRESIDING OFFICER. Is there objection to the request of the Senator from Montana?

There being no objection, the Senate resumed the consideration of the joint resolution (S.J. Res. 66) to provide for the designation of the period from August 31 through September 6, 1965, as National American Legion Baseball Week.

Mr. BREWSTER. Mr. President, the substitute measure offered by the minority leader, in my opinion, is just as inappropriate and retrogressive as was his original proposal last year.

The question of legislative reapportionment, of course, should be—and has been—carefully considered by the Judiciary Committee. The minority leader's proposal is apparently not favored by a majority of this committee. In any event, it should not be brought up as a hasty substitute for a completely unrelated resolution.

If agreed to, this constitutional amendment would be of critical importance in shaping the future path of our State governments. It would mark a long step away from truly representative government, for reasons which I would like to describe to my colleagues.

In order to arrive at my own position on this complex issue I found it necessary to go back and examine my own basic views of our American governmental way of life. I began with the

Constitution and the fundamental democratic philosophy which guided the Founding Fathers. I found myself asking questions that seemed simple, but proved otherwise. But by posing and answering those questions, I arrived at what I believe to be the most reasonable position on the tangled and controversial subject of apportionment of State legislatures.

The first question I asked was: Is there a clear and compelling need to alter the Constitution of the United States as the proponents of this amendment declared? I believe that our Federal Constitution is the greatest instrument of government ever devised by mankind. It has functioned so well as the charter of our democratic system that my instinct is to question any change in it unless the need for such a change can be clearly shown.

I certainly do not feel that the proponents of this amendment have in any way demonstrated the necessity of taking such a far-reaching and momentous step. Until they can produce substantial proof that the Constitution which has served so well thus far ought to be changed, I do not believe that this amendment should be adopted.

Second, I asked myself, Is this proposed amendment needed in order to achieve or preserve some fundamental right for the citizens of our Nation?

The answer, it seems to me, is "No." The right which is at issue here is the right of each citizen to have his vote count fully. The general principle enunciated by the Supreme Court in the case of Reynolds against Sims is that the vote of every citizen within a State—regardless of what color his skin is or where he lives within that State—should be given approximately the same weight as every other vote.

Such has not been the case in the past, of course. Apportionment of State legislatures has consistently given overrepresentation to the rural areas. Frequently a relatively small proportion of the population of a State has been in a position to elect a majority of the representatives in the legislature. What this means in effect is that a minority of the people rules—which is in flagrant contradiction to the basic democratic principle of majority rule.

In January 1964, voting statistics showed that, in 30 out of the 50 States, representation was so inequitable that a mere 40 percent or less of the people could elect a majority of the State senate. In the California Senate, 10 percent of the population could elect a majority. In Nevada, 8 percent of the voters could control the State senate in this manner. Some legislative districts were a hundred or more times larger than other districts in the same State—yet each district had one representative. This meant, in effect, that a rural vote might literally be worth a hundred city votes—a situation which is hardly consistent with our avowed democratic principles.

Following the Baker against Carr and other decisions, however, the situation

began to improve. The apportionment systems in 32 States were ruled unconstitutional last year. Ten of the legislatures voluntarily reapportioned themselves. The courts did it for them in three other States. Twenty-four States are currently under order to reapportion before the next election. Thus it appears that enforcement of the Constitution is beginning to guarantee to every man the right to his vote—a full vote, not a half, or even one-hundredth of a vote.

The amendment under consideration would alter the Constitution, to provide that in the elections for one house of a State legislature, some citizens' votes could be given greater weight than others. This amendment would at least partially undo the good work which has been done during the past year. Instead of preserving the rights of citizens, this would help create anew the situation in which those citizens residing in urban areas would be deprived of one of their fundamental rights.

Let me illustrate this by examining the effect this amendment might have on my own State of Maryland: 76 percent of the population of Maryland resides in the city of Baltimore and the four most populous counties in the State; namely, the suburbs of Baltimore and Washington. If equitable representation were required—as it will be unless such an amendment as the Dirksen amendment is enacted—this large majority of the population would elect the large majority of the Maryland Senate. Yet at present, this 76 percent of the population elects only 34 percent of the Maryland Senate—less than half of that to which it is entitled. Residents of these areas are in effect, given only half a vote. And the proposed amendment would continue this inequity. I fail to see what rights as citizens are thereby safeguarded; I see clearly that the right of urban and suburban residents to a free and full vote is seriously impaired.

Mr. NELSON. Mr. President, will the Senator yield for a question?

Mr. BREWSTER. I am happy to yield to the Senator from Wisconsin.

Mr. NELSON. Does the constitution of the State of Maryland provide for apportionment of the legislature, the senate on one basis and the lower body on another basis, or is it merely by an accident of history that disproportionate representation has developed?

Mr. BREWSTER. By custom and by law we have malapportionment in Maryland. This can be changed by an act of the legislature.

Mr. NELSON. It is not a constitutional question?

Mr. BREWSTER. That is my understanding.

Mr. NELSON. If the so-called Dirksen amendment were passed, would it be possible for the Senator's State to legally remain, along with other States, malapportioned as between the two houses?

Mr. BREWSTER. The Senator is entirely correct. We start with a situation in which one house of the legislature is entirely out of proportion with regard to representation. There is com-

plete small county and rural domination. Adoption of the Dirksen amendment would allow some legislatures that are not representative to continue malapportionment and to have an unrepresentative type of government.

Mr. NELSON. I thank the Senator.

Mr. BREWSTER. Mr. President, another question which occurred to me was: would the proposed amendment be justified by a sweeping change that has recently taken place? A constitution should be adaptable to the needs of changing times, and a great shift in the composition of American society has indeed taken place. From a onetime largely rural nation we have become an increasingly urbanized and suburbanized nation. Within our own generation that change has become evident to all. In my own State, over three-fourths of the people now live in Baltimore city and four suburban counties. But the amendment proposed would not help to adjust Maryland's government or the other State governments to that sweeping tide in American society. It would, in fact, move in the opposite direction. It would perpetuate the long-outdated dominance of rural minorities over the growing urban majorities. It would extend injustice and tend to impede progress.

A related question is: Would the amendment proposed improve the capacity of State governments to deal with the pressing problems that these new populations bring?

Let me stress at this point that I am a staunch believer in strong and effective State governments as a key element in our governmental system. I am forced to conclude that the amendment here proposed would not make State governments more responsible to the needs and desires of their people today or in decades to come. The opposite effect is more likely. In my own State, again, the amendment would make it possible for 15 senators who represent one-seventh of our people to maintain a veto over every piece of legislation needed by the State. That is more likely to be a recipe for frustration and stalemate than for responsible and effective State government.

I remember well, in my personal experience of 8 years' service in the General Assembly of Maryland representing Maryland's largest county, Baltimore County, a county of half a million population, that time and again what we considered progressive and imaginative measures were blocked completely by representatives who had little or no compatibility of interest with the points of view which the representatives from Baltimore County expressed.

Time and again, Congress has entered areas and passed statutes that are now the law of the land where in my opinion, the State governments should have taken over. In the Senate, and prior to that time in the House of Representatives, I have consistently supported civil rights legislation, because I believe in equal rights for all citizens. I wish it had been unnecessary for me to do this. I would much rather have seen the State of Maryland and all the other States in the Union take those actions on their

own, but when the States fail to act in areas concerning the entire Nation, Congress must step in.

Through the years, one of the reasons why the States have failed to act is that their legislative bodies have become ineffective due to malapportionment. Thus, far from taking away the rights of States, the proposition of one vote for one voter gives to the States the ability to enjoy true State's rights.

Now let me propound the fifth question. Will the constitutional amendment under consideration be necessary to protect the interests of rural minorities within States? I believe that question is the main concern of many fine and thoughtful people who sincerely believe this amendment is necessary. I feel that the answer is a twofold one. One answer is that none of us considers it necessary or appropriate to grant other minorities, such as racial or religious groups, the right to have their ballots count 5, 10, or 100 times as much as those of other citizens, so that they can protect their minority interests. So why should one particular kind of minority have such a privilege?

The second answer is that those who claim they need protection from the tyranny of urban and suburban areas have a misconception of those areas. Urban voters do not form a monolithic group having identical interests and always voting as a bloc. Rather, they are as diverse as the rural voters themselves, and usually far more diverse. Using the example of my own State again, citizens in Montgomery County, on the outskirts of the District of Columbia, exhibit quite different ideas and interests from those in Baltimore City, or in Anne Arundel, Howard, or Baltimore Counties. Even in the city of Baltimore, there are wide differences in the concerns and outlooks of the voters in the different parts of the city. In reality, there is no single, overwhelming urban majority. The voters there live closer together than the voters in rural counties, but they are just as diverse and just as likely to have their separate views on questions of public policy as those in less populated areas. Thus, there is no tyranny of urban voters to be feared. What is at stake, rather, is the right of diverse urban interests to have a vote equal to that of rural interests, one vote for one citizen.

Another question is: If a majority of the people of a State wish to apportion one house of their legislature on a non-population basis, why should they not be allowed to do so?

This is indeed a difficult question in a government which functions by majority rule. But under the Constitution as it stands, the right to an equally counted vote is, today, a basic constitutional right, as is the right to equal treatment regardless of religion or race—as are all the rights guaranteed by the first 10 amendments, the Bill of Rights, to the Federal Constitution.

Our democracy is based on the dual conception of majority rule—and the preservation of individual or minority rights. The people of a State cannot decide, even if a majority so desires, to impair the free and full vote of indi-

viduals in that State, any more than a majority can decide to suspend the Bill of Rights or the Constitution.

Accordingly, I feel that this question should, rather, be phrased: If the majority of the people in a State wish to deprive some of their citizens of the full right to vote, should they be allowed to do so? I believe that the answer is very clear; it is "No."

A final question which puzzles many people is: Does the fact that one House of the U.S. Congress represents governmental units instead of population mean that State legislatures should be structured in the same way? A study of the history of our Constitution and of our Nation shows that there is no constitutional or historical case for such a parallel.

The original American Union was composed of 13 separate and jealous sovereign States, among whom, I am proud to say, was my own State of Maryland. These States joined together to form a Federal union, but each State was anxious to retain a certain degree of sovereignty. Out of the genius of the Founding Fathers evolved the Connecticut Compromise. The representation of one House emphasized the union of the States: Members of the House of Representatives were to be elected to represent the people in each district. The representation of the Senate, on the other hand, emphasized the separate sovereignty of the States, as two Senators were chosen to represent each State. This brilliant compromise was necessary, in order to induce the 13 Independent States to unite in one Federal Government.

Such is not the situation in the States. It has never been a question, in my own State of Maryland, for instance, of inducing 23 sovereign counties and Baltimore City to unite in one State. There has never been any basis for representation by counties, rather than by population.

Those counties are themselves only the creation of the State, and are created by the State and the State legislature to carry out various governmental duties in an orderly manner within that State.

Those who argue that analogy to the Federal Government ignore the unique historical circumstances of 1789—circumstances which have no parallel in the States today.

The situation within the States today has been succinctly stated by the Supreme Court, in the Gray against Sanders case: "Within a given constituency, there can be room for but a single constitutional rule—one voter, one vote." And I can see no justification for altering our Constitution to provide otherwise.

The Supreme Court's decision does in fact allow States to deviate from a population basis to give a certain recognition to such subordinate units. That desirable flexibility is a far cry, however, from giving equal representation to counties in one house instead of to people.

So, Mr. President, if there is no constitutional or legal requirement for an amendment, the question is simply whether the change would improve the fairness of representation, and effective-

DIGEST of Congressional Proceedings

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HIGHLIGHTS: House agreed to conference report on housing bill. Rep. Monagan criticized rise in potato prices. Senate subcommittee voted to report Labor-HEW appropriation bill. Rep. St. Onge inserted statements favoring bill to establish marketing order for table eggs. Sen. Metcalf commended results of wheat certificate plan.

HOUSE

1. **HOUSING LOANS.** Agreed to the conference report on H. R. 7984, the housing and urban development bill (pp. 17743-51). Title X of this bill would provide a new \$300,000,000-per year program of insured housing loans under the Farmers Home Administration in rural areas. This bill will now be sent to the President.

2. HEALTH. Agreed to the conference report on H. R. 6675, to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the Old-Age, Survivors, and Disability Insurance System, etc. pp. 17729-43

Agreed to the conference report on S. 510, to extend and amend certain expiring provisions of the Public Health Service Act relating to community health services, which includes provisions extending until June 30, 1968, the program of health services to domestic agricultural migratory workers, and providing specific authorization for necessary short-term hospital care for such workers and their families (pp. 17752-3). This bill will now be sent to the President.

3. FARM PROGRAM. The committee report on H. R. 9811, the farm bill (see Digest 131), includes a summary of major provisions of the bill as follows:

"Dairy (title I).--The class I dairymen's base plan authorized in the first title seeks to reduce surplus milk production and stabilize the income of dairy farmers in Federal milk order areas by removing the necessity for dairymen to maintain maximum production in order to preserve individual participation in the markets for milk for fluid consumption. The dairy title... would assign to each producer in ^{a milk order area} a fluid milk base, which would enable him to receive the higher price for milk consumed in fluid form on a specified quantity of his production, in lieu of a blended price on total production used for fluid consumption and for manufacturing into butter, cheese, powdered milk, and other milk products. This title was not a part of the original omnibus bill proposed by the administration.

"Wool (title II).--The administration's proposal for changes in the wool program, to permit a system of graduated payments to producers based upon various levels of production, was not approved by the committee, which decided to continue the National Wool Act of 1954 through December 31, 1969. A floor of 77 percent of parity is set on wool price supports.

"Feed grains (title III).--This title continues for 4 years the provisions of the present feed grains program for price-support loans, purchases, and in-kind payments to program participants. In keeping with the price-support range at 65 to 90 percent of parity for corn (with comparable levels for grain sorghum, barley, oats, and rye), it provides the basis for support prices around levels of recent years. Participants by diverting acreage from feed grain production to conservation uses would receive, as in the past, payments in kind to help maintain income. Payments would be based on a percentage of price-support rates, on per-acre yields, and on acreage diverted, as previously. The Secretary of Agriculture could permit the diverted acreage to be devoted to guar, sesame, safflower, sunflower, castor beans, mustard seeds and flax, but not to soybeans. However, under certain conditions soybeans could be grown on permitted acres without loss of price support payments. Price support payments in kind could be varied and made only on part of the acreage planted for harvest.

"Cotton (title IV).--The one-price cotton program, wherein American mills buy U. S. cotton at the same price it is offered to foreign mills, is extended for 4 years, through 1969, with modifications. The new bill (1) continues the 16-million-acre national minimum allotment, but establishes a domestic allotment within the farm allotment which will be not less than 65 percent of each farm allotment, (2) requires at least a 15-percent reduction from farm acreage allotment for participation in the program, (3) permits any producer to stay out of the program and plant and sell without penalty at the market price.

and commendable bipartisan effort, of the parent House and Senate committees and the particular and exacting cooperative concentration and agreement of the conference committee. Their final recommendations to us very clearly represent a most conscientious and patriotic attempt to prudently and effectively deal with the complex subject of housing for the American people.

Mr. Speaker, the past record shows that, in general, our housing programs have been well administered and they have been exceptionally free from misuse of funds or authority. The provisions contained in this report now before us surely seem essential, from every objective viewpoint, for the vigorous continuation of programs that are vital to our efforts and our obligation to encourage more wholesome living conditions in better housing for all of our people.

Because it appears obviously in full accord with our national traditions, because it is designed to reasonably meet a fundamental national need and because it unquestionably tends to promote the health, safety and happiness of all our citizens, I hope this report will be overwhelmingly approved without further delay.

Mr. MULTER. Mr. Speaker, section 317 of this bill amends section 316(2) of the Housing Act of 1954 by making the provisions thereof applicable in the District of Columbia so that the District of Columbia Redevelopment Land Agency may undertake nonresidential projects in Washington, D.C.

That provision was in the Senate bill. It was not in the House bill.

It was not considered either in subcommittee, in full committee, or on the floor of the House, neither during debate nor under the 5-minute rule.

When consideration was sought in full committee, it was stated that the section had been eliminated from the House bill so that the matter could be studied at a later time.

This provision should not have been accepted by the House conferees.

The urban renewal program in the District of Columbia is the worst in the country. The District Committee has spent days studying the problem.

Several amendments to improve the District program had been unanimously approved by the District Committee which should be a part of any section extending this act to the District of Columbia. No opportunity is afforded us to accomplish that.

My objection to this provision being included in the bill goes beyond the matter of the Banking and Currency Committee's invasion of the jurisdiction of the District Committee. It goes to the dangerous procedure of legislating without hearings, and without consideration. It is bad enough to have inadequate hearings. It is inexcusable to have no hearings.

Mr. PATMAN. Mr. Speaker, I move the previous question.

The previous question was ordered.

The SPEAKER pro tempore. The question is on the conference report.

Mr. PATMAN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The question was taken; and there were—yeas 251, nays 168, answered "present" 2, not voting 12, as follows:

[Roll No. 204]

YEAS—251

Adams	Griffiths	Ottinger
Addabbo	Hagan, Ga.	Patman
Albert	Hagen, Calif.	Patten
Anderson,	Halpern	Pepper
Tenn.	Hamilton	Perkins
Annunzio	Hanley	Philbin
Ashley	Hanna	Pickle
Aspinall	Hansen, Iowa	Pike
Bandstra	Hansen, Wash.	Poage
Barrett	Hardy	Powell
Bates	Harris	Price
Beckworth	Hathaway	Pucinski
Bingham	Hawkins	Purcell
Boggs	Hays	Quillen
Boland	Hechler	Race
Bolling	Helstoski	Randall
Brademas	Hicks	Redlin
Brooks	Hollifield	Reid, N.Y.
Brown, Calif.	Holland	Resnick
Burke	Horton	Reuss
Burton, Calif.	Howard	Rhodes, Pa.
Byrne, Pa.	Hungate	Rivers, Alaska
Callan	Huot	Rodino
Cameron	Irwin	Rogers, Colo.
Carey	Jacobs	Ronan
Celler	Jarman	Roncallo
Chelf	Jennings	Rooney, N.Y.
Clark	Jeolson	Rooney, Pa.
Cleveland	Johnson, Calif.	Roosevelt
Clevenger	Johnson, Okla.	Rosenthal
Cohelan	Jones, Ala.	Rostenkowski
Conyers	Karsten	Roush
Corbett	Karth	Roybal
Corman	Kastenmeier	Ryan
Craley	Kee	St. Germain
Culver	Keith	St. Onge
Daddario	Kelly	Schlesler
Daniels	King, Calif.	Schmidhauser
Davis, Ga.	King, Utah	Schweiker
Dawson	Kirwan	Secrest
Delaney	Kluczyński	Senner
Dent	Krebs	Shipley
Denton	Kunkel	Sickles
Diggs	Landrum	Sisk
Dingell	Leggett	Slack
Donohue	Lindsay	Smith, Iowa
Dow	Long, Md.	Stafford
Dulski	Love	Staggers
Duncan, Oreg.	McCarthy	Stalbaum
Dwyer	McDade	Steed
Dyal	McDowell	Stephens
Edmondson	McFall	Stratton
Edwards, Calif.	McGrath	Stubblefield
Ellsworth	Machen	Sullivan
Evans, Colo.	Mackay	Sweeney
Everett	Mackie	Tenzer
Evins, Tenn.	Madden	Thomas
Fallon	Mathias	Thompson, N.J.
Farbstein	Matsunaga	Thompson, Tex.
Farnsley	Meeds	Trimble
Farnum	Miller	Tunney
Fascell	Mills	Tupper
Feighan	Minish	Tuten
Fino	Mink	Udall
Flood	Moeller	Ullman
Fogarty	Monagan	Van Deerlin
Ford,	Moorhead	Vanik
William D.	Morgan	Vigorito
Fraser	Morrison	Vivian
Friedel	Morse	Watkins
Fulton, Pa.	Mosher	Watts
Fulton, Tenn.	Moss	Weltner
Gallagher	Multer	Whalley
Garmatz	Murphy, Ill.	White, Idaho
Giaino	Murphy, N.Y.	Widnall
Gibbons	Natcher	Willis
Gilbert	Nedzi	Wilson,
Gilligan	Nix	Charles H.
Gonzalez	O'Brien	Wolff
Grabowski	O'Hara, Ill.	Wright
Gray	O'Hara, Mich.	Wydler
Green, Oreg.	O'Konski	Yates
Green, Pa.	Olsen, Mont.	Young
Greigg	Olson, Minn.	Zablocki
Grider	O'Neill, Mass.	

NAYS—168

Abbott	Arends	Betts
Abernethy	Ashbrook	Bolton
Adair	Ashmore	Bray
Anderson, Ill.	Ayres	Brook
Andrews,	Baldwin	Broomfield
George W.	Baring	Brown, Ohio
Andrews,	Belcher	Broyhill, N.C.
Glenn	Bell	Broyhill, Va.
Andrews,	Bennett	Buchanan
N. Dak.	Berry	Burleson

Burton, Utah	Gurney	Pelly
Byrnes, Wis.	Haley	Pirnie
Cabell	Hall	Poff
Callaway	Halleck	Pool
Carter	Hansen, Idaho	Quie
Casey	Harsha	Reid, Ill.
Cederberg	Harvey, Ind.	Reifel
Chamberlain	Harvey, Mich.	Reinecke
Clancy	Hébert	Rhodes, Ariz.
Clausen,	Henderson	Rivers, S.C.
Don H.	Herlong	Roberts
Clawson, Del	Hosmer	Robison
Collier	Hull	Rogers, Fla.
Conable	Hutchinson	Rogers, Tex.
Conte	Ichord	Roudebush
Cooley	Johnson, Pa.	Rumsfeld
Cramer	Jonas	Satterfield
Cunningham	Jones, Mo.	Saylor
Curtin	King, N.Y.	Schneebeli
Curtis	Kornegay	Scott
Dague	Ladd	Selden
Davis, Wis.	Langen	Shriver
de la Garza	Latta	Sikes
Derwinski	Lennon	Skubitz
Devine	Lipscomb	Smith, Calif.
Dickinson	Long, La.	Smith, N.Y.
Dole	McClory	Smith, Va.
Dorn	McCulloch	Springer
Dowdy	McEwen	Stanton
Dowling	McMillan	Talcott
Duncan, Tenn.	MacGregor	Taylor
Edwards, Ala.	Mahon	Teague, Calif.
Erlenborn	Mailliard	Teague, Tex.
Findley	Marsh	Thomson, Wis.
Fisher	Martin, Ala.	Tuck
Flynt	Martin, Mass.	Utt
Foley	Martin, Nebr.	Waggoner
Ford, Gerald R.	Matthews	Walker, Miss.
Fountain	May	Walker, N. Mex.
Frelinghuysen	Michel	White, Tex.
Fuqua	Mize	Whitener
Gathings	Moore	Whitten
Gettys	Morris	Williams
Goodell	Morton	Wilson, Bob
Griffin	Murray	Wyatt
Gross	Nelsen	Younger
Grover	O'Neal, Ga.	
Gubser	Passman	

ANSWERED "PRESENT" 2

Scheuer	Todd
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NOT VOTING—12

Battin	Cahill	Macdonald
Blatnik	Colmer	Minshall
Bonner	Keogh	Toll
Bow	McVicker	Watson

So the conference report was agreed to.

The Clerk announced the following pairs:

On this vote:

Mr. Keogh for, with Mr. Colmer against.
Mr. Toll for, with Mr. Bonner against.
Mr. McVicker for, with Mr. Watson against.
Mr. Blatnik for, with Mr. Battin against.
Mr. Macdonald for, with Mr. Minshall against.

Mr. PIKE changed his vote from "nay" to "yea."

Mr. ROBERTS changed his vote from "yea" to "nay."

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

(Mr. SCHEUER asked and was given permission to address the House for 1 minute.)

Mr. SCHEUER. Mr. Speaker, I would like to clarify for the record that on rollcall No. 204 concerning H.R. 7984, I was present but did not vote because I felt I had a direct personal interest in the legislation, and, under rule 8 of the House was precluded from voting thereon.

CORRECTION OF THE RECORD

Mr. O'HARA of Michigan. Mr. Speaker, on page 17474 of the CONGRES-

SIONAL RECORD for Monday, July 26, I am quoted as saying:

I did not have any reference to voluntary contributions through the so-called buck drives or coke drives conducted by many organizations.

The word, "coke," obviously is incorrect. What I actually said was "COPE drives."

I ask unanimous consent that the word "COPE" be substituted in the permanent RECORD for the word "coke" in my remarks.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan?

There was no objection.

COMMUNITY HEALTH SERVICES EXTENSION AMENDMENTS OF 1965

Mr. HARRIS. Mr. Speaker, I call up the conference report on the bill (S. 510) to extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes and ask unanimous consent that the statement of the managers on the part of the House be read in lieu of the report.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

The Clerk read the statement.

(For conference report and statement see proceedings of the House of July 23, 1965.)

Mr. HARRIS. Mr. Speaker, this conference report is on the extension of several very important and necessary programs. It will be recalled that the Congress in the past established a program of intensive community immunization programs, established a program of health services for domestic agricultural migratory workers, and established programs of grants for State health programs and special projects for community health services.

H.R. 2986, extending these programs, passed the House some time back by a vote of 347 yeas to no nays. We then substituted this text for the text of S. 510, a similar bill that had passed the other body. The amendment went to the other body and they agreed to a conference. We went to conference, and we have endeavored to resolve the differences. I feel that we have fairly well maintained the position of the House. There was some modification in the position of both Houses, and we bring to you today a unanimous conference report.

There are three questions involved. First is the immunization program. The House proposed to extend the present program for 3 years with an authorization of \$11 million a year. The Senate included a 5-year program with \$8 million a year. The conferees agreed on an extension of 3 years and \$11 million, which was the same as the House had passed.

There was another difference in the immunization program between the House amendment and the Senate bill

in that the Senate version permitted advance payments on the basis of estimates to the States and local agencies carrying out immunization programs, and modified certain record-keeping requirements. The House bill had no such provision.

We accepted the provision for advance payments on the basis of estimates, but the conference report does not include the provision relating to a modified record keeping. In view, however, of the conference substitute, and in view of the language already in the act which authorizes grants for costs reasonably attributable to the protection of the eligible age group, the conferees expect that the Surgeon General will review with the States and local agencies affected methods for simplifying record-keeping requirements. We think by this method it will work out satisfactorily and will alleviate unnecessary burdens.

The second difference between the two Houses in connection with this conference report has to do with the provision of health services for domestic agricultural migratory workers. The Senate bill extended the program for a period of 5 years and for this 5-year program, they would have authorized a total of \$34 million. Since the House has established a pattern of authorizing these programs for 3-year periods in order that the Congress may at the end of that time review what the programs have accomplished, the House version provided a straight extension of 3 years with the current authorization of \$3 million. In view, however, of the expected demand the conferees extended the program for 3 years as provided in the House bill and for fiscal year 1966, we authorized \$7 million; \$8 million for 1967 and for the third and final year this authorization of \$9 million. These were the amounts authorized in the Senate version.

We believe that these amounts will be sufficient to provide the needs anticipated in this program for the next 3 years.

The conference agreement also includes specific authorization for necessary short-term hospital care for domestic agricultural workers and their families. This was a provision in the Senate bill, but it was not in the House amendment. It is the intention of the conferees that the authority for hospital care will be utilized on a limited basis and in accordance with the priorities established by the Surgeon General. We wanted to make this abundantly clear and we feel that where emergencies arise they will be taken care of, and yet it will not put a burden upon local hospital facilities.

The third point of difference in this conference has to do with the schools of public health. Many of our colleagues here in the House were quite concerned about the lack of increased authorization for these schools when the bill was reported and considered in the House. We authorized for these 12 public health schools in the United States a straight extension of the existing \$2½ million authorization. The Senate provided a \$5 million authorization. In view of the fact that there are 12 of these schools and

that they have increased their enrollment, and that we are establishing two additional schools of public health, the House conferees felt that the Senate authorization would be more justified and consequently we adopted the authorization included by the other body of \$5 million.

I think many Members in the House will be gratified that the House conferees agreed to this provision of the Senate amendment. The conferees feel that this program is a very necessary program.

We feel that the conference agreement is a reasonable compromise, and, therefore, we urge the adoption of the report.

(Mr. HARRIS asked and was given permission to revise and extend his remarks.)

Mr. HARRIS. Mr. Speaker, I yield to the gentleman from Illinois [Mr. SPRINGER] such time as he may require.

Mr. SPRINGER. Mr. Speaker, several programs of proven merit are included in this bill. The value of immunization programs is well enough known and needs no extensive justification at this time. Extension of the program to include measles has become feasible because of a breakthrough in scientific research which should make it possible to eradicate this common but dangerous disease, mostly in children. Because of the progress made in recent years in the means to vaccinate against diseases which killed or maimed large numbers within our population, it seems wise to leave the door open for prompt action in the event that other dramatic developments make new immunization programs practical. This bill does so.

The health of migratory workers poses acute problems for those communities to which they come for relatively short periods of time each year. Although there may not be one easy answer which would apply to each and every situation, we do know that the Nation must take cognizance of the problems. The provision of extra manpower for the affected health service agencies has proved to be most useful within the communities affected. Because of the peculiarity and diversity of State laws and local ordinances the provisions of emergency hospital services has been difficult or impossible in many cases. The funds provided by this bill are not meant to solve this dilemma in its entirety but it does provide for emergency hospital services on a limited scale until better answers can be found.

Grants to support general public health services and special project grants for community health services throughout the Nation are not new. This bill would merely extend the program for 1 year at present levels.

A comprehensive look at this situation must be taken by the next Congress. The reappraisal is called for only because of the evolutionary changes in community health services. I would not want to see any cutting back or any changes whatsoever in this particular program until we have the benefit of studies now underway.

I believe we did as good a job in conference as the House could expect and I believe the conference report is such that it ought to be approved.

(Mr. SPRINGER asked and was given permission to revise and extend his remarks.)

GENERAL LEAVE

Mr. HARRIS. Mr. Speaker, I ask unanimous consent that all Members may extend their remarks in the RECORD at this point on the conference report.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

Mr. HARRIS. Mr. Speaker, I have no further requests for time. I move the previous question.

The previous question was ordered.

The conference report was agreed to. A motion to reconsider was laid on the table.

HEALTH RESEARCH FACILITIES AMENDMENTS OF 1965—CONFER- ENCE REPORT

Mr. HARRIS. Mr. Speaker, I call up the conference report on the bill (H.R. 2984) to amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes, and ask unanimous consent that the statement of the managers on the part of the House be read in lieu of the report.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

The Clerk read the statement.

(For conference report and statement, see proceedings of the House of July 23, 1965.)

Mr. HARRIS. Mr. Speaker, this bill would extend what is commonly referred to as the health research facilities program. This program over the years has proved itself. We have reaped rich benefits from it.

It may be recalled that when the bill passed the House some weeks ago it was on a rollcall vote of 333 to 4.

There is only one difference between the bill as passed by the House and the conference agreement.

The bill passed by the House provided for a 3-year authorization for contract authority by the Public Health Service, with a limitation of \$43 million as a ceiling on annual obligations. The Senate amended this to delete both the 3-year limitation and the \$43 million limitation.

We felt that the three-year limitation was more in keeping with the pattern we had set. However, we receded on the limitation of the \$43 million on annual obligations.

I should like to explain that no additional money is involved. This is a method of contracting. The NIH, the Public Health Service, probably will contract outside of the Government's actual operations itself, for the current

fiscal year about \$94 million of the total funds appropriated for research facilities to the Public Health Service. These funds go primarily to the NIH.

It was thought if we could use private sources, we could obtain the desired results or, at least, we might get better results by using this practice. So it is a question of not tying the hands of the Public Health Service but permitting them to utilize private sources in a free enterprise manner insofar as it would become feasible to do so. After careful analysis of the entire situation, we felt it would be to the best interests of the Service to accede to the Senate provision with reference to the \$43 million limitation which the House previously included in the bill.

One other matter that was in conference, but is not in the conference report or the House bill should be discussed. When our committee originally considered the bill, we deleted from the bill a proposed 6-year authorization for non-matching grants for construction and operation of specialized regional or national research facilities.

The bill passed the House without this feature, as I have indicated. The Senate version, as reported and as passed, restored the authorization but limited the duration to 4 years, with a maximum appropriation authorization of \$35 million.

The conferees struck out this provision for regional facilities on the basis that the committee now has under consideration a bill referred to as the regional complexes, and we believe it would be more appropriate to give consideration to this in connection with that program. With this we had a unanimous conference report and we commend it to the House and urge its adoption.

Mr. Speaker, I now yield to the gentleman from Illinois [Mr. SPRINGER].

Mr. SPRINGER. Mr. Speaker, the provisions of this bill, which provide an extension of section 704 of the Public Health Service Act, to make possible the construction of health research facilities for the next 3 years, is a continuation of the very successful partnership between Government and the academic world to provide the space in which the research vital to the health of the American public can be accomplished. This provision, in conjunction with the grants made to individuals and institutions for research work, provides the major authority and the machinery for the accomplishment of health research.

There are some instances wherein grants are not the proper inducement for desirable and required research projects. In such instances the Department of Health, Education, and Welfare has in the past made contracts with private industrial or other institutions to take on specific studies, whether long or short range in nature. The authority to use the contract method has been maintained only through language in the appropriation acts from year to year. It is not considered good business to base such important projects on such a shaky platform. The authority should be clear

while yet being well within the control of the authorizing committee. This bill grants the authority to use contracts as well as grants for the next 3-year period. The Congress can then review the history of this authority and the way it has been used. In my view, the two sections of the Public Health Service Act, which I have here described, give ample authority to create facilities for health research and to provide for those instances in which grants are not adequate to induce specific research. In stating this position I am mindful of the section in the original bill which contemplated a series of Federal installations to carry on research in those subjects not attractive to universities or other research institutions. As long as it is possible to offer contracts covering all phases of any such research I am sure that qualified institutions will accept the task.

Also provided for in this legislation are three additional assistant secretaries for the Department of Health, Education, and Welfare. In view of the extent of new health legislation and other new responsibilities for the Department, it seems proper that these positions should be provided. I would wish to serve notice, however, on the Department and the administration that I shall personally watch very closely the way in which these positions are utilized. Although I do not purport to speak for our entire committee I am sure that as a body it will expect close surveillance of the manner in which these additional positions are used.

(Mr. SPRINGER asked and was given permission to revise and extend his remarks.)

GENERAL LEAVE TO EXTEND

Mr. HARRIS. Mr. Speaker, I ask unanimous consent that all Members may be permitted to revise and extend their remarks at this point in the RECORD on the conference report if they so desire.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

Mr. HARRIS. Mr. Speaker, I move the previous question on the conference report.

The previous question was ordered.

The conference report was agreed to. A motion to reconsider was laid on the table.

MENTAL FACILITIES AND CENTERS CONSTRUCTION ACT

Mr. HARRIS. Mr. Speaker, I call up the conference report on the bill (H.R. 2985) to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers and ask unanimous consent that the statement of the managers on the part of the House be read in lieu of the report.

The Clerk read the title of the bill.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

The Clerk read the statement.

(For conference report and statement see proceedings of the House of July 23, 1965.)

Mr. HARRIS (interrupting the reading of the statement). Mr. Speaker, I ask unanimous consent that the further reading of the statement be dispensed with.

The SPEAKER. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

Mr. HARRIS. Mr. Speaker, I yield myself 5 minutes.

Mr. Speaker, this is a very important program. Since it passed the House 389 to 0, I thought that it perhaps might be unnecessary to utilize much time in explaining it. I do think, however, it would be appropriate if we did explain some of the differences between the House and Senate versions and what we did accomplish in conference.

Amendment No. 1 only changed the short title of the bill to conform to the changed text. Naturally, the House receded on it.

With regard to amendment No. 2, in the House bill, authority was given to the Secretary of HEW to make grants to community mental health centers to finance a portion of the cost of the staff of these centers with assistance to be furnished to any one center for a total period of 51 months.

The House bill authorized the Secretary to commence such grants at any time during the 3 fiscal years 1966, 1967, and 1968, and authorized appropriations for those 3 fiscal years and the succeeding fiscal year. This would not have permitted completion of payments to centers, but future authorizations would have been required.

The Senate amendment made no change in the 3-year period during which the grants could be commenced, and authorized appropriations for the next 4 fiscal years, so as to permit completion of the payment of the Federal share with respect to each center for the full 51 months. This is a reasonable modification and the House conferees agreed to it.

The third difference was that the Senate amendment No. 3 amended section 302 of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 to continue research and demonstration projects in the training of handicapped children, and increased the authorization for the current fiscal year to \$6 million. Additional appropriations authorized under the Senate amendment for the following 5 years would aggregate a total of \$78 million.

The House receded with an amendment. We increased the authorization for the current fiscal year to \$6 million and limited the extension of the program to 3 additional years, with the same authorization for these years as was contained in the Senate amendment: \$9 million for fiscal year 1967, \$12 million for fiscal year 1968, and \$14 million for fiscal year 1969, or a total of \$35 million for the 3 additional years.

We think this would meet the needs as explained to us and we think that the record bears that out.

There were five further amendments which would add four new subsections to the above-mentioned section 302 that would expand and clarify the program of research and demonstration projects for training of handicapped children. The new subsection (f) would add authority for construction, equipment, and operation of facilities for research, research training, surveys, or demonstrations to aid handicapped children. The subsection includes experimental schools also.

The new subsection (g) is the usual provision requiring conformance with the Davis-Bacon Act on the construction program. The House receded on that. The other two subsections contain definitions, and we receded on these, of course.

Amendment No. 9 would permit the Secretary of Health, Education, and Welfare to deposit in a special account on the books of the Treasury all or part of any grant awarded by the Secretary, and to make payments from this account from time to time to the extent needed to carry out the purposes of the grant. The reason for this was that we wanted the Secretary to be able to pay grants at the right time, not to have to pay them in advance and have Federal funds lying in a bank while the grantees were formulating a program or were otherwise getting ready to use the funds. The House receded on this amendment.

Amendment No. 10 extends the application of the act of September 6, 1958, relating to the training of teachers of handicapped children to the Commonwealth of Puerto Rico, the Virgin Islands, the District of Columbia, Guam, and American Samoa. The House receded on that.

Amendment No. 11 provides a 5-year extension of the program under the act of September 6, 1958, which is the real heart of this program, Mr. Speaker. This act authorizes grants for training professional personnel in all areas of the handicapped. The Senate version extended this program for 5 years with additional appropriations totalling \$186 million. The House acceded to the Senate version, with modifications. We limited the appropriations for the current fiscal year to \$19½ million and authorized appropriations for 3 additional years instead of 5, with \$29½ million, \$34 million, and \$37½ million, respectively, authorized for fiscal years 1967, 1968, and 1969. In this way we did revise the entire program.

Mr. Speaker, I believe it is conceded that this will provide a much more effective program for those unfortunate people who need attention, afflicted as they are, in the field of mental health and mental retardation.

Therefore, Mr. Speaker, we commend this unanimous conference report to the House.

Mr. Speaker, I yield such time as he may consume to the gentleman from Illinois [Mr. SPRINGER].

(Mr. SPRINGER asked and was given permission to revise and extend his remarks.)

Mr. SPRINGER. Mr. Speaker, as explained by the distinguished chairman of the Committee on Interstate and For-

eign Commerce, the gentleman has covered the amendments in detail as they actually occurred in the conference.

It is true that there were 11 amendments considered in the conference. I believe that we did about as good a job as could be done under the circumstances. In fact, the differences between the Senate and the House in my estimation were quite minor. To a great extent the Senate and House bills conformed.

Mr. Speaker, in my estimation this is one of the important pieces of legislation to come out of our committee this year and I believe that the conference report ought to be approved. The greatest strides in health legislation, as well as in public awareness in recent years, have been in the field of mental health and mental retardation. The first major change in public policy affecting care and treatment for the afflicted in these areas has come about in a short period. The great weight of the evidence indicates that early local assistance and treatment for both mental illness and mental retardation should increase dramatically the incidence of recovery and return to a useful and productive existence.

Congress accepted this premise and provided a program for the construction of local facilities to be known as community mental health centers and community retardation facilities. At that time it was suggested that the Federal Government assist in the initial staffing of these facilities. This was not done at the time. Now that the program is underway and the very real problems begin to emerge, it becomes clear that in the case of community mental health centers some such staffing assistance is justified and necessary.

This bill provides for a 3-year period, during which such institutions may apply for staffing grants. It is necessary, of course, to fund the last application as fully as the first and since the bill provides for approximately 4 years of declining assistance it is necessary to authorize funds for a 4-year period beyond the last application.

Not included in the House bill but added by action in the other body are provisions to increase and extend research and demonstration projects in the education of handicapped children and also extend and increase the program for grants to institutions of higher learning to provide for training teachers of handicapped children. I heartily endorse these additional provisions because I am keenly aware of the great benefit to the Nation at large, as well as to the individuals involved, of such training. Special training for teachers in this field needs every possible encouragement.

The SPEAKER. The question is on the conference report.

The question was taken and the Speaker announced that the ayes appeared to have it.

Mr. SPRINGER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.



Public Law 89-109
89th Congress, S. 510
August 5, 1965

An Act

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "June 30, 1965" and by inserting "and each of the next three fiscal years," immediately after "June 30, 1965,". The second sentence of such subsection is amended by striking out "the fiscal years ending June 30, 1963, and June 30, 1964" and inserting in lieu thereof "any fiscal year ending prior to July 1, 1968". The third sentence of such subsection is amended by striking "and tetanus" and inserting in lieu thereof "tetanus, and measles", and by striking out "under the age of five years" and inserting in lieu thereof "of preschool age".

76 Stat. 1155.
42 USC 247b.

79 STAT. 435.
79 STAT. 436.

(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem through immunization with vaccines or other preventive agents which may become available in the future."

Other infectious
diseases.

(c) Subsection (b) of such section is amended by striking out "of limited duration", by striking out "against poliomyelitis, diphtheria, whooping cough, and tetanus" and inserting in lieu thereof "against the diseases referred to in subsection (a)", and by striking out "who are under the age of five years" and inserting in lieu thereof "of preschool age".

(d) (1) Such section is further amended by striking out "intensive community vaccination" wherever it appears in subsections (a), (b), and (c) and inserting in lieu thereof "immunization".

(2) The heading of such section is amended by striking out "INTENSIVE VACCINATION" and inserting in lieu thereof "IMMUNIZATION".

(e) Paragraph (1) of subsection (c) is amended by inserting "on the basis of estimates" after "advance"; by striking out the comma after the word "reimbursement" and inserting in lieu thereof "(with necessary adjustments on account of underpayments or overpayments)".

MIGRATORY WORKERS HEALTH SERVICES

SEC. 3. (a) Section 310 of the Public Health Service Act is amended by striking out "for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed \$3,000,000 for any year, as may be necessary" and inserting in lieu thereof "not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, and \$9,000,000 for the fiscal year ending June 30, 1968".

76 Stat. 592.
42 USC 242h.

76 Stat. 592.
42 USC 242h.

(b) Such section is further amended by inserting "including necessary hospital care, and" immediately after "agricultural migratory workers and their families," in clause (1) (ii) of such section.

GENERAL PUBLIC HEALTH SERVICES

60 Stat. 424;
75 Stat. 824.
42 USC 246.

SEC. 4. (a) The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

79 STAT. 436.
79 STAT. 437.

(b) The third sentence of subsection (c) of section 314 of such Act is amended by striking out "\$2,500,000" and inserting in lieu thereof "\$5,000,000".

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

75 Stat. 824.
42 USC 247a.

SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

Approved August 5, 1965.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 249 accompanying H. R. 2986 (Comm. on Interstate & Foreign Commerce) and No. 676 (Comm. of Conference).

SENATE REPORT No. 117 (Comm. on Labor & Public Welfare).

CONGRESSIONAL RECORD, Vol. 111 (1965):

Mar. 11: Considered and passed Senate.

May 3: Considered and passed House, amended, in lieu of H. R. 2986.

July 26: Senate agreed to conference report.

July 27: House agreed to conference report.

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